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*ARGUMENT*

ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

*Scott (cont'd)*

Hearing held  
21 floor  
180 Dundas Street West  
Toronto, Ontario

*Parents*

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamok, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

*request for*

*stated case*

Transcript of evidence  
for

June 13, 1984.

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN  
AND RELATED MATTERS

Hearing held on the 21st Floor,  
180 Dundas Street West, Toronto,  
Ontario, on Wednesday, the 13th day  
of June, 1984.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

APPEARANCES:

P.S.A. LAMEK, Q.C.	)	Commission Counsel
E. CRONK	)	
D. HUNT	)	Counsel for the Attorney
L. CECCHETTO	)	General and Solicitor General
		of Ontario (Crown Attorneys
		and Coroner's Office)
I.G. SCOTT, Q.C.	)	Counsel for The Hospital
M. THOMSON	)	for Sick Children
R. BATTY	)	
D. YOUNG	)	Counsel for The Metropolitan
		Toronto Police
W.N. ORTVED	)	Counsel for numerous Doctors
K. CHOWN	)	at The Hospital for Sick
		Children
B. SYMES	)	Counsel for the Registered
F. KITELY	)	Nurses' Association of Ontario
		and 35 Registered Nurses at
		The Hospital for Sick Children
D. BROWN	)	Counsel for Susan Nelles -
		Nurse

(Cont'd) ...







APPEARANCES (Continued):

G.R. STRATHY	)	Counsel for Phyllis Trayner -
P. RAE	)	Nurse
J.A. OLAH	)	Counsel for Janet Brownless -
		R.N.A.
S. LABOW	)	Counsel for Mr. & Mrs. Gosselin,
		Mr. & Mrs. Gionas, Mr. & Mrs.
		Inwood, Mr. & Mrs. Turner, Mr. &
		Mrs. Lutes, and Mr. & Mrs.
		Murphy (parents of deceased
		children)
F.J. SHANAHAN	)	Counsel for Mr. & Mrs. Dominic
		Lombardo (parents of deceased
		child Stephanie Lombardo); and
		Heather Dawson (mother of
		deceased child Amber Dawson)
W.W. TOBIAS	)	Counsel for Mr. & Mrs. Hines
		(parents of deceased child
		Jordan Hines)
J. SHINEHOFT	)	Counsel for Lorie Pacsai and
		Kevin Garnet (parents of
		deceased child Kevin Pacsai)





I N D E X

ARGUMENT BY MR. SCOTT (CONTINUED)

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---On commencing at 10:00 a.m.

3

THE COMMISSIONER: I heard from Mr.

4

Sopinka this morning. He is in the Court of Appeal

5

on Monday but he doesn't expect to waste too much

6

time with us. So if he starts at 9:30 on Monday

7

morning he will be able to attend to all his affairs.

8

So I told him we would start at 9:30 on Monday with  
him and presumably everybody, at least Mr. Scott and

9

Mr. Ortved will have been disposed of by that time.

10

Yes. All right, Mr. Scott.

11

ARGUMENT BY MR. SCOTT (CONTINUED)

12

MR. SCOTT: Mr. Commissioner, the

13

thrust of the submissions that I made to you yesterday

14

was that it was important that the Commission in  
approaching its task should proceed cautiously in

15

those areas where the scientific and other data

16

suggested limitations of knowledge, and that you

17

should in particular not feel obliged to answer

18

questions where the evidence did not provide you with

19

a full level of assurance that the answers were

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sound. That you were not a delphic oracle that was

21

bound to respond simply because the questioner

22

appeared before you, and that in particular it was

23

important not only to the parents but to the Hospital

24

and to the public that the answers you give on the

25

A  
DM/cr







1  
2 evidence where you can answer the questions should be  
3 answers insofar as possible that should be on a  
4 rationalized basis and should stand the test of time  
5 insofar as that is humanly possible. That therefore  
6 it was going to be necessary for you to construct  
7 some guidelines within which you would approach your  
8 task as a general proposition. I suggested to you  
9 nine guidelines that I thought were appropriate,  
10 always with the rider that if you did not feel that  
11 the evidence warranted an assured answer it was an  
12 appropriate response in the public interest to say,  
13 on the level of knowledge that we have I simply  
14 cannot answer this question, or I cannot deal  
15 particular with the death of this baby.

16 Later I will be suggesting to you  
17 that there are only six cases of the 36 which provide  
18 any adequate evidentiary foundation for a finding of  
19 foul play, or a finding of digoxin involvement and  
20 death.

21 Now it will be for you to say whether  
22 in those cases the evidence warrants that conclusion,  
23 but it will be my submission that there are only six  
24 where the evidentiary foundation is adequate to even  
25 commence the task.

Before getting to the individual cases





1  
2 I want however to review, I hope without repeating  
3 any of what Mr. Lamek has said, some of the evidence  
4 in front of you with respect to the operation of the  
5 Hospital, the role of Doctors in diagnosis, the role  
6 of the pathologists in diagnosis, the evidence about  
7 the understanding of digoxin current in 1981, and then  
8 come to the babies.

9 Now the first portions of what I say  
10 are historical but are important nonetheless and  
11 derive really from the Dubin Report and the CDC  
12 Report. In the Dubin Report particularly, which you  
13 have, the Hospital is fully described.

14 It is as you know a 700 bed Hospital,  
15 University affiliated, which provides patient care  
16 services primarily for children, research facilities  
17 and professional training facilities. Since 1915  
18 when it was founded the Hospital has specialized  
19 in providing concentrated medical care for children  
20 together with paediatric expertise to the whole  
21 medical community. As a result patient referrals  
22 are accepted from all other hospitals in Metropolitan  
23 Toronto and from other areas of Canada and the  
24 United States. The institution has become a major  
25 teaching and referral hospital with respect to  
paediatric populations, including particularly for our







1  
2 purposes children with either congenital or acquired  
3 cardiac diseases.

4 It goes without saying, and I am  
5 grateful that most counsel have acknowledged that  
6 the Hospital has deserved a longstanding reputation  
7 within the paediatric medical community, and has drawn  
8 leading experts in various fields to practice within  
its walls.

9 The Hospital's role in teaching and  
10 research has enabled it to attract some of the world's  
11 most highly regarded paediatric physicians and  
12 surgeons, and a number of them gave evidence before you  
at this Commission.

13 It is acknowledged by the independent  
14 experts who also gave evidence to be in the forefront  
15 of advancement in medical technology, preventive  
16 medicine and research.

17 Now the nature of the institution as  
18 a teaching and research hospital, and the high calibre  
19 of its medical resources and skills make it unique  
20 in Canada insofar as it endeavours to treat patients  
21 who are considered to be poor medical risks and for  
22 whom established treatment and established treatment  
centres offers little or no hope.

23 This emphasis on tertiary care as it  
24  
25







1  
2 is called has led by necessity to a high incidence of  
3 death which often drains the staff, as well as the  
4 parents of the children who have been unable to survive.

5 As the Dubin Report notes from its  
6 inception in 1915 the Hospital's philosophy has had  
7 three elements: (1) to provide the best medical  
8 service, including patient care, training and research.  
9 (2) to meet the needs of the immediate community in  
10 the full range of child health care services.

11 (3) to make available to any child regardless of  
12 his place of residence the services, skilled staff  
13 and resources that the Hospital commands.

14 The staff of the Hospital is very  
15 considerable. In January 1983 and the figures are  
16 not markedly different for 1981, the Hospital had over  
17 400 medical staff, 240 house staff, including Fellows,  
18 Residents and Interns, and approximately 2800 Hospital  
19 employees, which includes a nursing staff of 1133.

20 You have noted, sir, and other counsel  
21 have acknowledged I am grateful to say, that the  
22 quality of the staff, their devotion to duty, their  
23 skill and diligence, their caring attitude for children  
24 and their concern for the parents of the children,  
25 and these characteristics I do not hesitate to say  
have evoked the admiration of the medical community





1  
2 and the public in Canada and abroad.

3 As the Dubin Committee concluded the  
4 Hospital has earned an international reputation for  
5 the quality of the services provided to its patients.  
6 As the Dubin Committee also said the institution is  
7 still deserving of that reputation and of the complete  
8 confidence of the public, it is an indispensable  
9 Canadian institution.

10 Nonetheless the events of July 1980  
11 to March 1981 on Wards 4A and 4B of the Hospital have  
12 greatly shaken not only the public at large but also  
13 the staff, medical and nursing, of the institution.  
14 The confusion and frustration arising out of that  
15 troubled period have, I am glad to say, led to complete  
16 co-operation between the Hospital and your Commission  
17 staff. I need hardly point out that long hours have  
18 been spent reviewing Hospital charts and other records,  
19 and extensive interview sessions have been spent with  
20 Commission staff in preparation for testifying and  
21 providing to you all the evidence, pro and con, one  
22 side or the other, that may be of assistance to you.

23 In excess of 30 employees or former  
24 employees have testified before the Commission and many  
25 others have been intensively interviewed.

Now as we know, prior to April of







1  
2 1980 the Cardiology Ward of the Hospital was located  
3 on the fifth floor. In April the Cardiology and  
4 Cardiac Surgery Services were transferred to Wards  
5 4A and B. This transfer increased the number of ward  
6 beds from 38 to 42. Ward 4A has 19 beds, 12 of  
7 them infant beds, and Ward B has 23 beds. There is  
8 a central nursing station flanked by two six bed rooms,  
9 one on each ward, where the smallest and usually the  
10 sickest patients are assigned. These are known as  
Rooms 418 and 431.

11 The services that are provided by  
12 the cardiologists, the cardiovascular surgeons, the  
13 intensive care unit and the nursing staff at the  
14 Hospital are available in few if any hospitals in  
15 Canada, and only two or three in North America. Thus  
16 children with serious cardiac ailments are sent to  
17 this Hospital, and as I have noted from many other  
18 hospitals in Canada and the United States where  
services cannot be provided at an adequate level.  
19 There are inherent risks in procedures performed on these  
children.  
20 Even in cases of some immediate progress in their  
21 treatment many of these patients still have a very  
22 short life expectancy. In particular and in addition  
23 there are high risk patients, many of them under one  
24 year of age and sometimes, as you will have seen, sir,  
25





1  
2 only a few days old.

3 In the past it was a truism to say  
4 that little could be done for many of these patients  
5 save to make them comfortable during their all too  
6 brief lives. This type of care known as palliative  
7 care is at time particularly stressful for staff,  
8 especially the nursing staff. But now heroic efforts  
9 can be made in certain institutions to save the lives  
10 of children who would not have had such an opportunity  
11 in the past. But there is a down side, these new  
12 and aggressive treatments including high risk  
13 correctional surgery, but many treatments stopping  
14 short of surgery necessitates tremendous commitment  
15 and devotion from the staff and lead to exposure to  
16 substantial risk.

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B-1

DP/ac

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2 Many of the cardiac conditions  
3 demonstrated in the children admitted to wards 4A  
4 and 4B carry, as Dr. Rowe said, a high morbidity rate.  
5 You only have to look at the volumes. In a 12 month  
6 period approximately 1,100 infants and children are  
7 admitted to the ward and it is reasonable to assume  
8 that between 800 and 950 were cared for on wards 4A  
9 and 4B during the period under investigation by the  
10 Royal Commission. While no doubt it is a saddening  
11 aspect of such a cardiac ward, it is expected by  
12 doctors and nurses alike that a certain number of  
13 these infants will succumb to their cardiac anomalies  
14 while patients under care in these wards. This  
15 must be especially so for high risk babies of which  
16 there are in the period under review a substantial  
17 number.

18 I want to focus on a point that  
19 Dr. Rowe, Dr. Cutz and others made about the approach  
20 of the medical community to the problems that it  
21 confronts in diagnosis and I do this to emphasize  
22 that the approach of doctors as scientists to the  
23 examination and the resolution of a medical problem  
24 is not the approach that would be traditional with  
25 lawyers. Medical doctors are trained in the scientific  
mode. They approach each patient from the basis of





B.2

1  
2 the factual data or information being presented  
3 to them by the patient's condition, the clinical  
4 examination, laboratory tests, x-rays, echocardiograms and cardiac catheterization, and from this  
5 body of raw material the physician determines the  
6 primary and the differential diagnosis. He does  
7 not create any hypothetical possibilities. Rather  
8 he searches for possibilities that arise from the  
9 facts or the data base itself. He does not add  
10 any possibility onto his list of diagnoses that  
11 does not have some factual foundation in objective  
12 data as it relates to a particular patient. He  
13 does not deal, and this will be odd to lawyers,  
14 in trends, statistics or averages. The last case  
15 does not exist in the diagnosis of the next case.  
16 Although cases may have in the end common features  
17 each case for a doctor must be examined uniquely  
18 and be diagnosed exclusively on the facts that case  
19 alone reveals. That is the scientific approach. It  
20 is quite unlike the approach that lawyers frequently  
21 are obliged to take in the resolution of problems that  
22 come before us but it has been the approach that has  
23 led to the major advances in scientific knowledge.

24  
25  
When a cause of death is assigned  
by a physician, the physician looks for the underlying







B.3

1  
2 cause in cardiac cases that gave rise to the  
3 stoppage of the heart contractions. In trying to  
4 determine underlying causes, again there is no  
5 reference to statistics, trends, or averages, the  
6 physician takes whatever information is available  
7 in support of or, on the other hand, against the  
8 specific cause. The physician, true to his oath,  
9 never assigns as an underlying cause something for  
10 which there is no evidence. No physician believes  
11 that he can determine the cause of death with any  
12 absolute certainty. Physicians recognize that no  
13 conclusion is often the best conclusion because it  
14 represents the state of knowledge at the time. The  
15 physician makes a judgement on the balance of  
16 probabilities and on the basis of the information at  
17 hand as to the probable cause of death and Dr. Rowe  
18 dealt with that at Volume 20, page 3555 and following.

17 The pathologist in a teaching  
18 hospital, as Dr. Cutz made clear, tries to assist the  
19 clinician in charge of diagnosing the disease. He  
20 is not a coroner or a forensic expert. He is a  
21 scientist providing a support service in diagnosis.  
22 The pathologist's job is to try to determine  
23 whether the diagnosis was correct and what can be  
24 learned from the case under consideration. In doing  
25





B.4

1  
2 an autopsy, the pathologist again adheres to the  
3 cause of death presented by the evidence and only  
4 by the evidence.

5 As you have heard from Dr. Cutz there  
6 are three types of findings which can be made,  
7 anatomical, biochemical and pathophysiological.  
8 Anatomical findings imply a kind of lesion or  
9 abnormality that can be seen with either the naked  
10 eye or microscopically which either by previous  
11 experience or knowledge would be considered as being  
12 significant to cause death. Biochemical findings  
13 are determined by measurements of substances either  
14 endogenous to the body or drugs in the blood or  
15 tissues. By determining the levels and interpreting  
16 them in the context of a specific case a biological  
17 abnormality may be considered as the cause of death.  
18 The pathologist takes blood samples and provides  
19 them to biochemistry for analysis. The pathologist  
20 then has to interpret the findings in light of  
21 the entire case. The pathologist thus is dependent  
22 in a major way on expertise which may be provided  
23 by a pharmacologist when he either consults one  
24 personally or reads the available literature.

25 Pathophysiological findings as you  
have hear suggests a disturbed function. The effect







B.5

1  
2 of this disturbed function can occasionally be  
3 observed during life and may indeed have been  
4 measured before life. There may be a correlation  
5 between the functional abnormality and an anatomical  
6 finding but often there's no lesion that can be  
7 pinpointed as being the anatomical cause of the  
8 pathophysiology.

8 In addition as you have heard  
9 from Dr. Ernest Cutz the pathologist is dependent  
10 in part on the readings made during life such as  
11 electrical readings of the heart or brain. The  
12 person essentially responsible for the analysis  
13 of those readings is not the pathologist but is  
14 rather the clinician and it is a function of the  
15 pathologist to determine whether there is any  
16 correlation between the readings and any anatomical  
17 disorder which may be discovered.

17 The pathologist thus assesses an  
18 autopsy with a view to determining the nature and  
19 severity of the disease and whether or not there  
20 was a reasonable anatomical cause of death. He  
21 reports his findings to the clinician whose clinical  
22 diagnosis is confirmed or augmented. What is learned  
23 through a particular child's death is applied in  
24 the treatment of other children who are believed  
25





B.6

1  
2 to be suffering from the same abnormality. Thus  
3 the learning process continues in the effort to improve  
4 the treatment of all children with cardiac lesion.  
5 It is for the precision of this learning exercise  
6 the pathologist limits his comments to the probable  
7 cause of death suggested by the evidence presented.  
8 Therefore, sir, respectfully, when a comment is  
9 made that the pathological report is not particularly  
10 helpful at this Commission what we are saying is it  
11 is not particularly helpful to our forensic purpose.  
12 That process is not designed for our forensic purpose,  
13 it is designed for the Hospital's internal scientific  
14 purpose and it must be recognized that having been  
15 designed for that, it by and large fulfills that  
16 scientific need. Criticism because we cannot make  
17 use of it in the way we would like to do is criticism that  
18 is (a) unwarranted and (b) entirely beside the  
19 point.

20 In his review of the pathology  
21 reports of the children under investigation, Dr.  
22 Derek deSa, in Exhibit 283, said this, looking at the  
23 report:

24 " ... I was concerned with whether or not  
25 there was any evidence of cardio-  
megaly or hypertrophy of any one





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" particular chamber of the heart;  
whether the myocardium had been  
sampled histologically with a view  
to excluding any ischemic lesions,  
whether other organ systems such as  
kidney, brain, liver and gastrointestinal  
tract showed any effects of the  
congestive cardiac failure .....  
that would explain the clinical status  
of the infant. I recognized that  
there were, inevitably, likely to be  
instances when a perfect correlation  
would be impossible, since morphologic  
methods are, essentially, limited  
in their scope. "







C/RD/ko

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2 Dr. deSa refers in that report to  
3 evidence and concludes that with the exception of  
4 three cases, the babies Woodcock, Hines and Pacsai,  
5 there is good evidence that the infants were  
6 extremely sick, that death was inevitable and anatomi-  
7 cal causes of death were present in abundance. Those  
8 are his words.

9 Thus I take issue when Mr. Lamek makes  
10 a point leading to a suspicious inference and bases it,  
11 in part at least, on the fact that there were some  
12 cases where the pathologist could not assign a cause  
13 of death. Of course, there are some cases where a  
14 scientific pathologist cannot assign a cause of death.  
15 That is not a matter for suspicion when you understand  
16 what a scientific pathologist does. It may be a matter  
17 of suspicion in a forensic exercise; it is not a matter  
18 of suspicion and, therefore, not a matter from which  
19 any significant conclusion can be drawn in the course  
20 of a scientific exercise.

21 THE COMMISSIONER: Surely it is  
22 something if we are considering a death, the fact that  
23 the pathologist hasn't discovered a cause of death  
24 requires further consideration; does it not?

25 MR. SCOTT: The pathologist's function  
isn't to discover a cause of death in that sense.





C 2  
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2 THE COMMISSIONER: Well, perhaps not,  
3 but his ~~forum~~<sup>m</sup> has a calling for it.

4 MR. SCOTT: With the greatest of  
5 respect, sir, lawyers are confounded by two things:  
6 we deal with forensic pathologists who have that  
7 function. Most of us in this room have never seen a  
8 scientific pathologist or heard from one. We deal with  
9 forensic pathologists and, as Dr. Cutz indicated,  
10 they perform an entirely different function. We are  
11 dealing here with reports of scientific pathologists,  
12 and while it is also again natural for lawyers to say,  
13 as you and I did only yesterday, sir, we must come to  
14 a conclusion. No scientist says that he must come to  
15 a conclusion. That is fundamentally at odds with the  
16 scientific principle in which it is recognized that  
17 there will be many cases when you cannot scientifically  
18 come to a conclusion. That is a fact.

19 All I am saying is that is not a matter  
20 of suspicion in scientific circles. It is an  
21 acknowledged recognition that we don't know everything  
22 and to pretend that we do is foolish. Therefore, when  
23 you say that the scientific pathologist could not  
24 assign a cause of death that is a fact that can be  
25 taken, but it does not point in any direction. It  
simply means that the cause of death will have to be







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determined by the clinician or by others, experts,  
what have you. It doesn't mean that there is any  
doubt that the patient may have died of natural  
causes. You cannot turn it into a negative inference.

Dr. Cutz made perfectly plain that if  
the autopsies in these cases had been done with the  
forensic outlet the reports might have been quite  
different. *Jawson?*

THE COMMISSIONER: What happens though?  
The matter is referred to the coroner and the coroner  
then retains this scientific pathologist at the  
Hospital for Sick Children. Aren't they at  
odds --

MR. SCOTT: No. You may hear it in  
another phase, but when a case is reported to the  
coroner he retains the pathologist. He would naturally,  
in the City of Toronto, if the case was a pediatric  
cardiac case, retain the pathologist at the Sick  
Children's Hospital, because their expertise is so  
great and a coroner gives a direction if he thinks it  
is appropriate to the pathologist. He outlines the  
concerns that have been voiced to him, the areas of  
concern and asks the pathologist to see, not if the  
clinician's conclusion alone can be supported, but  
rather whether there are any, there is any pathological





1  
C 4 2 foundation for these areas of concern.

3 The coroner directs the exercise and so  
4 he must. Now, in some cases the direction will be more  
5 routine naturally than in others, but there is no doubt  
6 that a coroner's pathological examination, as Dr. Cutz  
7 said, and there is no evidence to the contrary, is  
8 different than a scientific.

9 THE COMMISSIONER: I take it what you  
10 are saying or perhaps you are saying, is that a  
11 coroner has some obligation to look around. The  
12 scientific pathologist may not.

13 MR. SCOTT: Yes.

14 THE COMMISSIONER: He may simply take  
15 what is there in front of him and make the best he can  
16 of it or make nothing of it if he can't make anything  
17 of it. But surely if a coroner is going to hire a  
18 pathologist and the pathologist knows he is hired by  
19 the coroner then surely he should recognize the  
20 purpose of it and find out the cause of a death.

21 MR. SCOTT: If he gets direction, yes.

22 THE COMMISSIONER: Doesn't he know  
23 enough automatically? If the coroner says here, I want  
24 you to undertake this inquest or this inquiry for me,  
25 doesn't he know that is what the coroner wants to know?

MR. SCOTT: The sense is that you find the





C 5

1  
2 cause of death if you turn over enough stones and  
3 under one of those stones you are going to find the  
4 cause of death. That isn't, as you can see from this  
5 exercise, which has taken you a year, what happens at  
6 all and all I am saying is that the pathologist --  
7 Mr. Lamek has made a point of the fact, which is why  
8 I respond, that the fact that the pathologists were  
9 not able to assign a cause of death as a factor that  
10 should lead you to a suspicion level of a certain type.  
11 Now if he hadn't said that I wouldn't be making this  
12 submission. I am simply saying, and we are going to  
13 have to take them one by one, that where there is  
14 toxicological data you may have some base for a  
15 conclusion, but the other factors that Mr. Lamek puts  
16 to you, including the fact that the pathologist has not  
17 reached a forensic conclusion, is not a factor that  
18 weighs one way or the other in determining the issue  
19 before you.

20 You will know, for example, even in a  
21 coroner's case, it isn't the pathologist who assigns  
22 the cause of death, it is the coroner. The pathologist  
23 merely reports his findings and if he is directed to  
24 make findings in a particular area he will make those  
25 and he reports them.

The coroner, the forensic person assigns







1  
C 6 2 the cause of death.

3 THE COMMISSIONER: He does it entirely  
4 on the basis of a pathologist report.

5 MR. SCOTT: No, he does it on the  
6 basis of the material that he thinks right and you  
7 will have heard, in I think some cases, that the  
8 coroners, having obtained the pathologist report,  
9 interview the clinicians. Why? It isn't an interview  
10 just for the fun of it; it is because the coroner is  
11 collecting what information he thinks appropriate to  
12 assign a cause of death and one source of that infor-  
mation are the findings of the pathologist.

13 The simple point I make is that the  
14 fact that a pathologist is not able to assign a cause  
15 of death cannot be a factor in escalating or de-  
16 escalating suspicion level in any of these cases.  
17 It would come as a considerable shock to the medical  
18 community if the fact that a pathologist was unable  
19 to assign a cause of death were taken, no matter how  
minimally, as evidence of a certain kind of death.

20 THE COMMISSIONER: Well, I don't know  
21 whether I am entirely with you or not, but certainly  
22 it sounds persuasive. Let me just put it the other  
way.

23 MR. SCOTT: I am not sure I am going  
24  
25





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1  
2 to be put off that easily.

3 THE COMMISSIONER: If we find the  
4 bullet wound in the head of the patient, the deceased,  
5 and the pathologist, not unreasonably thinks that  
6 bullet has an effect upon the termination of life,  
7 that is certainly a positive factor, something they  
8 would have found that would write off, certainly help  
9 to write off any thought of some more obscure things,  
10 such as digoxin toxicity - would it not? - so it does  
11 have an effect. The fact that he was unable to find  
12 something, wasn't able to find anything that he could  
13 point to as the specific cause of death, it may be  
14 neutral. We can't, from that, say there was digoxin  
15 toxicity.

16 MR. SCOTT: That's precisely it, it is  
17 neutral. Dr. Cutz, you will remember, took you through the  
18 14 types of death that Dr. Rowe had illustrated and made  
19 plain, and I will be coming to it, that most of those  
20 deaths if they occurred, many of them, could not be  
21 revealed by a pathological examination. I mean even  
22 congestive heart failure, if it had not been protracted,  
23 say for a period of time, would not be revealed by the  
24 pathologist.  
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The point I simply make is, with the greatest of respect, Mr. Lamek is saying something; he seems to leave as soon as I begin, but he is making a submission --

THE COMMISSIONER: To make it all the easier for you.

MR. SCOTT: He is making a submission that would come as a considerable shock to the medical community, if I understand his submission to be that the finding that no cause of death can be assigned by the pathologists is a suspicious factor; it is not a suspicious factor on the evidence before you. It is simply a limitation on the pathologists' science.

If he felt obliged to come to a conclusion on every case he wouldn't be a good pathologist to begin with. There are many cases where they cannot assign a cause, and where the cause of death would not be revealed by pathological examination. That is why the clinician is in charge. It is just like saying we will let the X-ray technician decide the cause of death. The X-ray technician only sees a minor part of the whole picture. Now you may be able to tell from an X-ray, I mean if I present you with an X-ray where all the bones are broken in 25 places, you and I may be able to conclude that there

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DM/cr

Not  
my  
submission  
at all!





1  
2 is a high possibility that he died of broken bones,  
3 or an automobile accident. There will be a thousand  
4 things, things that are going to kill you and me and  
5 most of us in this room that won't be revealed by any  
6 X-ray, and the X-ray technician will come back and say  
7 I can't tell you how the patient died, and Mr. Lamek  
8 will say, well, it must be a suspicious death.

9 The pathological examination is one  
10 of the aids to a clinician. Like any other of the  
11 technical services, the technical support services  
12 that are provided in a hospital. There will be many  
13 instances where the pathologist is not able within the  
14 limits of his science to determine the cause of death,  
15 and his inability to do so is not a matter of  
16 suspicion or comment but is an ordinary matter in  
17 the nature of the scientific process at all hospitals.

18 Now a coroner on the other hand, as  
19 we have said, is operating under a different discipline.  
20 It is for the coroner, not the pathologist, to assign  
21 a cause of death and for him, if he thinks it is  
22 appropriate, to order an autopsy, or to order any  
23 other examinations, interviews, reviews of charts,  
24 et cetera, that he considers appropriate. His primary  
25 purpose, unlike the pathologist, is to make some  
determination, if he can, as to the cause of death.





1  
2 His findings will be based not merely on the autopsy  
3 but on all the factors that he is able to review  
4 surrounding the death of the adult or the child.  
5 Of course, if he is unable - if a coroner in exercising  
6 his forensic capacity having reviewed the material is  
7 unable to make that conclusion he has the right,  
8 although it is not necessary in every case, to appoint  
9 an inquest to make the determination under his direction,  
10 but in his place.

11 Now, I want to deal with another  
12 matter that Mr. Lamek has placed considerable stress  
13 on as one of the indicia which may heighten your  
14 level of suspicion. Because I have grave reservation  
15 about the way that Mr. Lamek uses the child's clinical  
16 course and the phrase "sudden or unexpected" in  
17 relation to the child's death as a foundation for  
18 an inference leading to foul play. There is no  
19 doubt that he does that because one of his categories  
20 is exclusively categories of babies where there is  
21 suspicion of varying degrees based in large part on  
22 the sudden or unexpected nature of their death  
23 revealed by their clinical course.

24 The question you have to ask yourself,  
25 with the greatest respect is, is that a factor which I  
can take into account as probative of anything. In







1  
2 my respectful submission to you, sir, it will be a  
3 factor that if it has any value in your exercise it  
4 is value of such a low standard that it will be of  
5 no practical use in deciding how the babies died and  
6 by what means.

7 Dr. Rowe testified - there has been,  
8 first of all, a substantial amount of testimony from  
9 a variety of doctors about sudden and unexpected,  
10 usually in which they express their conclusion that  
11 this was sudden, or this was unexpected, or this was  
12 sudden and unexpected, or it was neither sudden nor  
13 unexpected.

14 Dr. Rowe testified, just so that we  
15 will have it clear, at Volume 11, page 1795 that the  
16 words "unexpectedly and suddenly" are used differently  
17 in a hospital setting than in a non-hospital setting.  
18 That they have naturally a significant subjective  
19 component that varies from doctor to doctor. They are  
20 not words of science, they are words of observation.  
21 Most of the time it is not possible for a hospital  
22 staff member to make a prediction, as you can under-  
23 stand, as to the moment when a baby with a congenital  
24 heart disease will die. A baby may die suddenly but  
25 that would not necessarily be unexpectedly, we come  
that far. As will be seen the heart can fail at any





1 moment completely. Therefore, for example, when Dr.  
2 Bain did his review of the charts in the summer of  
3 1982 he noted with respect to certain babies, and  
4 I quote:

5 "That they may have died a little  
6 sooner than might have been expected."

7 Dr. Rowe also testified at the page  
8 I noted, that with experience doctors do get a feel  
9 for how long a child may be expected to survive with  
10 a given condition, but as he said, they are proved  
11 wrong many times.

12 In addition to make the problem more  
13 complex, certain underlying causes of death are not  
14 apparent from the clinical course of the child and  
15 therefore cannot be put into the crucible from which  
16 it is determined that death is expected. Frequently  
17 the clinicians must await the autopsy findings to  
18 determine if the child succumbed unexpectedly or  
19 expectedly, and therefore you may have a doctor who  
20 says I didn't expect this baby to die; and a  
21 pathologist may say, having seen the pathology, well  
22 it is not your fault you couldn't see what I have now  
23 seen, but you should have expected, you knew every-  
24 thing, you would have expected this child to die.

25 There is not, in other words, anything  
like the precision in the use of these words that we







6 1  
2 have been using for a year "sudden and unexpected",  
3 that we have invested in them. The estimate of life  
4 expectancy is no more than a rough description for  
5 each patient.

6 For example, Alan Perreault on the  
7 other side had a malformation that usually ends life  
8 within four or five days, he survived for 27 days,  
9 during which his death was expected I suppose for  
10 every one of the 27 days. But in the end it was not  
11 his death which was unexpected it was his life, and  
12 that shows that these terms simply do not have the  
precision that we would like to invest in them.

13 Now I make that point because  
14 when you come to analyse the death of the individual  
15 babies and you are told that the sudden and unexpected  
16 feature of his death is a factor that you may take  
17 into account in escalating your suspicion level, we  
18 want to know exactly what is involved in that, because  
19 in my respectful submission it is not and it cannot  
20 be particularly when you have two clinicians who come  
21 to different conclusions about whether it is sudden  
22 and unexpected, sudden or unexpected, neither or both.

23 When you look at the cases you will  
24 see that there is very great variability in these  
25 estimates. What you will want to judge these cases





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2 on is objective raw material, not this kind of evidence  
3 which is so important to the clinician in approaching  
4 the case, but so highly variable, and so often in the  
5 nature of the process, wrong.

6 Now it should be noted particularly  
7 that in Volume 12, page 2057 and following, Dr. Rowe  
8 dealt with the morbidity review of January. He was  
9 anxious to make it plain that when the cases for that  
10 review were selected the definition of "expected and  
11 unexpected" was again a different definition than the  
12 clinicians used in the course of their day-to-day  
13 conferences. At the morbidity review conference the  
14 phrase "unexpectedly" referred to babies that the  
15 clinician had, in his word, hoped to get through  
16 and this referred to the possibility of prolonging life  
17 by medical interventions such as surgery or ventilation.

18 Dr. Rowe testified that the question  
19 of whether these children should or should not have  
20 died, could or could not have been retrieved, or saved,  
21 or repaired, recognizing always the variation in odds  
22 that can occur with any particular child with a  
23 particular deformity, had to be considered as part of  
24 the definition used at that conference of "unexpected".  
25 So within the very format of this case we have two  
definitions of "unexpected or sudden". The morbidity





1  
2 review definition and the clinician's day-to-day  
3 definition.

4 In cross-examination by Mr. Hunt  
5 Dr. Rowe testified, Volume 23, page 4134, that he had  
6 characterized the terminal events of a good number of  
7 babies as sudden, but not unexpected. He stated that  
8 if the anatomical abnormalities were of such a nature  
9 or so severe that it makes it likely that a baby is  
10 going to die, then when the baby dies the death is  
11 not viewed as an unexpected death. This, however, does  
12 not exclude the possibility that the death is a sudden  
13 one.

14 In Mr. Lamek's examination of Dr.  
15 Fowler reference was made to Exhibits 175 and 176.  
16 175 is a paper in the Canadian Medical Association  
17 Journal entitled "Sudden Unexpected Death in Children  
18 with Congenital Heart Disease". The ages represented  
19 in those studies are children of one to 21 years.  
20 Exhibit 176 is Chapter 18 out of Dr. Rowe's text book  
21 on "Infant Cardiology" published in 1978 called  
22 "Sudden Death-Treatment of Cardiac Arrest".

23 Although these studies suggest that  
24 for patients over the age of one year there is a small  
25 incidence of sudden and unexpected death, the populations  
on which the studies are based have to be carefully







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1  
2 considered in the light of the populations that you  
3 have to consider in this Commission.

4 With the exception of the three older  
5 children, Murphy, Heyworth and Floryn, the population  
6 that we are considering here is made up of children  
7 all of whom are under the age of one year. The babies  
8 Dawson, Velasquez and Miller are almost one year of  
9 age, but the vast majority of the others are con-  
10 siderably less than a year and some of them only days.  
11 within the context of these studies no statistics  
12 are available on children under the age of one year  
with respect to "sudden and unexpected".

13 Dr. Fowler testified that - I am  
14 sorry, I don't have the volume, I will try and get  
15 it. Dr. Fowler testified that research did support  
16 the proposition that children with a variety of  
17 cardiac problems may die suddenly. In the same way  
18 Dr. Bain, who is certainly an eminent and experienced  
19 paediatrician, testified about Baby Lutes that sudden  
death did not in that context concern him.

20 At Volume 62, page 3956, he said:

21 "That babies get sick quickly and  
22 die quickly", and I think he went on  
23 to say that they heal quickly, that the whole process  
24 in dealing with babies is one that occurs at that  
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kind of speed; they get sick quickly, if they are  
going to heal they heal quickly, so they can be out  
in a couple of days where you and I would be there for  
months lingering and trying to get some energy, but  
if they don't heal they die quickly, and that is a  
view in my respectful submission that would be shared  
universally by cardiologists and paediatricians.

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E.1.

DP/ac

1  
2 Nor is this <sup>not</sup> a view that only is shared by the  
3 Hospital cardiologists. In direct examination  
4 Dr. Hastreiter testified, Volume 77, page 6820  
5 and following that it should be understood, he said,  
6 with young babies such as those being discussed  
7 before the Commission sudden deaths are more likely  
8 to occur than in older babies and that they may  
9 occur without any previous symptoms and for example  
10 a child may be doing well and die suddenly.  
11 Similarly in cross-examination by Mr. Ortved,  
12 Volume 80, page 7339 he confirmed again and gave  
13 examples that he was always aware of the fact that  
14 infants with congenital heart disease can and do  
15 die suddenly. They die by virtue of their disease  
16 and their state, by virtue sometimes of the fact  
17 that they have had surgery at an early age and  
18 by virtue of their young age these courses are in  
19 many respects unpredictable. I put this to you simply  
20 to emphasize that sudden and unexpected is a most  
21 unreliable guide to escalate your suspicion level in  
22 these cases and that you will want to look in the  
23 end, if you seek a rational conclusion, as you do, that  
24 can be sustained on toxicological data.  
25

Now it is in the context of these  
statements about sudden and unexpected that the

Adm

this -

dormit

flow from

beginning!





E. 2

1  
2 cardiologists at the Hospital reviewed the charts  
3 of the children under investigation. In the vast  
4 majority of cases it was clear that the deaths were  
5 completely consistent with the clinical condition  
6 of the particular child. Where the deaths were felt  
7 to be sudden, unexpected and not consistent with the  
8 known condition of the child at death the Hospital  
9 notified the coroner as in the cases of Woodcock  
10 and Velasquez. Commission Counsel also in his  
11 statement the other day attached some importance to  
12 the fact that infants under investigation could not  
13 be resuscitated following their cardiac arrest and  
14 he referred particularly to the unsuccessful  
15 resuscitation, but that is not a factor that points  
16 anywhere in terms of causality. It is imperative  
17 to re-emphasize Dr. Rowe's testimony based on the  
18 literature that only 11% of resuscitation attempts  
19 are ever successful, Volume 10, page 1727. What  
20 is unknown in the context of this case is the number  
21 of resuscitation attempts within the epidemic period  
22 which were successful.

23 THE COMMISSIONER: Is that right?

24 MR. SCOTT: I know of no evidence.

25 Because the Commission has examined only those babies  
who died he had not been asked for and there is no evidence



1  
2 of whether there are successful resuscitation  
3 attempts and what they are.

4 The point I make here again is that  
5 the failures - Mr. Lamek had an adjective that  
6 describes the failure rate - the depressing failure  
7 rate of resuscitation efforts. But the depressing  
8 failure rate is not documented in the evidence. The  
9 rate for resuscitations in the average hospital is  
10 11%. There is no evidence that we fell below that  
11 rate in the epidemic period and even if there were  
12 that in my respectful submission would not be  
13 evidence on which you could safely and prudently rely  
14 in escalating your suspicion level.

15 THE COMMISSIONER: I am a little  
16 surprised with that information because I remember  
17 worrying about it. We never got it, I suppose.

18 MR. SCOTT: I do not have any note  
19 that we did. I will look at it again, I may be  
20 wrong. I suppose it could be obtained. The difficulty  
21 is that we focussed immediately on the babies that  
22 died. A baby that is successfully resuscitated,  
23 a baby, maybe, I suppose if any of these babies had  
24 previously been resuscitated --

25 THE COMMISSIONER: There was one,  
Janice Estrella.







E. 4.

1  
2 MR. SCOTT: Janice Estrella was,  
3 we had a note of that because we looked at the whole  
4 record of that baby, but we don't know how many  
5 resuscitations succeeded because our focus was  
6 broad enough, mind you, but --

7 THE COMMISSIONER: One of the nurses  
8 were asked if there were any - we will investigate  
9 that.

10 MR. SCOTT: The point I make is that  
11 if you accept that in the epidemic period roughly  
12 somewhere between 800 and 950 babies went through  
13 these two wards and we know nothing about the  
14 resuscitation efforts, you may make a comment. You  
15 can make any comment about the resuscitation efforts  
16 that you want but it is not a pertinent comment .  
17 to observe that there is a depressing failure rate.  
18 Even if you want to make that observation it is  
19 not an observation that leads you logically to any  
20 inference.

21 Now I would like to come to the  
22 underlying causes of death and I want to make here  
23 the same points that some of the matters you have  
24 been asked to consider are not probative of anything  
25 and in the end you are going to have to fall back,  
no matter how inadequate it may be, on the toxicological





E.5

1  
2 data.

3 In the course of reviewing the  
4 deaths as he so completely did, Mr. Lamek referred  
5 in considerable detail to the nature of terminal  
6 events. If I may respectfully infer the purpose  
7 of that was to escalate or de-escalate as appropriate  
8 the suspicion level pointing to the possibility of  
9 foul play. Look at how the baby died. We have  
10 dealt with sudden and unexpected. Now look at  
11 the mechanism of dying in order to see if you can  
12 draw an inference from that. It is my submission  
13 that though we would like to do it, I mean it would  
14 be helpful to have all these guideposts, that that  
15 is not a reliable or assured guidepost by any means  
16 in which you can find assistance in assessing the  
17 difficult question that you have before you.

18 At Volume 4, Dr. Mirkin cited the  
19 symptoms of digoxin toxicity as being AV block,  
20 ventricular fibrillation, bradycardia, nausea,  
21 vomiting, hallucination and confusion. Yet as  
22 Dr. Kauffman on the other hand and other experts have  
23 testified the symptomatic signs of digoxin toxicity  
24 in infants are completely non-specific and are  
25 almost invariably symptoms that can be due to many  
other factors than digoxin. Dr. Kauffman noted in







B.6

1  
2 Volume 73 at page 5991 and following that digoxin  
3 symptoms can reflect other conditions including  
4 the child's underlying state, and at page 6215 he  
5 also said in using symptoms of seizure, vomiting,  
6 high respiratory rate or whatever it is almost  
7 impossible to say individually that they are a sign  
8 of digoxin poisoning because so many other things  
9 can cause all of those symptoms.

10 If that is so and I accept it, you  
11 cannot say that the symptoms point in any direction.  
12 What does that mean for lawyers and judges? It  
13 means that they are neutral, that they do not get  
14 put in the scales on one side or the other because  
15 they are not probative.

16 Similarly Dr. Hastreiter in cross-  
17 examination by Mr. Ortved noted, and this is Volume  
18 80, page 7396, that death due to digoxin intoxication  
19 can mimic what may very well be a natural death.  
20 Digoxin he says has no specific symptoms as such  
21 and terminal events can be related to many different  
22 things. It is therefore difficult and may be impossible  
23 in many situations in a clinical setting to be  
24 certain whether or not a specific symptoms is due or  
25 not to digoxin toxicity in a child. In particular,  
the arrhythmias demonstrated are often found in the

(N.D.)  
No ref to  
ECG - detection  
symptoms.





E.7

1  
2 terminal events of any child with a congenital  
3 heart disease in the process of dying. In addition  
4 vomiting and irritability are also found in  
5 conjunction with chronic heart failure.

6 Dr. Bain testified, at Volume 62,  
7 page 3894 that he found evidence of convulsions  
8 or seizures in 16 of the 36 babies under investigation,  
9 Dawson, Hoos, Turner, Shrum, Monteith, Murphy,  
10 Velasquez, Adamo, Volk, Estrella in December, Fazio,  
11 Leith, Pacsai, Gardner, Miller and Cook. Dr. Bain  
12 went on to testify that in his opinion seizures  
13 were not consistent with digoxin intoxication. He  
14 cited from Dr. Fowler's work which is before you  
15 as Exhibit 174 an article entitled "Accident Digitalis  
16 Intoxication in Children" where Dr. Fowler determined  
17 in his examinations that of the 31 children studied  
18 only one demonstrated any symptoms of convulsions.

19 Generally this phenomena in association  
20 with digoxin intoxication is unexplained. It should  
21 be fairly noted that Dr. Kauffman and Dr. Hastreiter  
22 were asked to address this issue. In Volume 75,  
23 page 6609, Dr. Hastreiter testified that seizure  
24 activity could be caused by many different factors  
25 but was also a finding in massive digitalis intoxica-  
tion. He found record of that in the literature.





E.8

1  
2 Similarly in Volume 73, Dr. Kauffman  
3 was asked about the incident of seizures in the  
4 terminal events. He stated that the incidence of  
5 seizures was not necessarily that high and that  
6 he was unsure of the cause of the seizures. He  
7 proposed that in the Miller child the seizures may have  
8 resulted from atoxia or <sup>? hyponoxia?</sup> acidosis in the terminal  
9 stages of the child's life. He indicated that the  
10 seizure might not be from digoxin toxicity but rather  
11 from the rapid deterioration of the child. In his  
12 opinion the seizure activity was consistent with  
13 the cardiac status.

14 So what you have even at this area  
15 is a considerable division of opinion as to the  
16 relevance of seizure activity in these children.  
17 It is not symptomatic of anything. It is one of  
18 a host of symptoms that may not be probative or  
19 may not logically lead to one conclusion or the  
20 other.

21 Apart from seizures, in my  
22 examination of Dr. Rowe, reference was made to other  
23 causes of cardiac arrest which would be mimiced  
24 by possible digoxin intoxication. This examination  
25 is found in Volume 19, page 3320 and following.  
The point of it is if you look, for example, at







E.9

1  
2 Dr. Nadas who appears to have been obliged to  
3 give a one sentence answer - it is extraordinary  
4 the number of answers which state consistent with  
5 cardiac state, not inconsistent with digoxin  
6 intoxication. Why is that? Well, Doctor, you are  
7 being unresponsive, I want to know which it is.  
8 The truth is that these factors do not point in  
9 any direction in particular and the reason I make  
10 this point, apart from the toxicological data was  
11 one Mr. Lamek's points in dealing I think with one  
12 of his categories that this pointed in that direction.  
13 In my respectful submission it would be dangerous  
14 to draw any conclusion that is founded in part on  
15 that as a characteristic. If that is all you have  
16 got, you have not got nearly enough.

17 THE COMMISSIONER: You have said  
18 two things, you say it would be dangerous to draw any  
19 conclusion founded in part on that, and then you went  
20 on to say that that is all you have got.

21 MR. SCOTT: Let me put it this way.  
22 That is not a factor from which any conclusion  
23 flows at all. There may be other factors, toxicology,  
24 on which you can rely, but I say resuscitation efforts,  
25 sudden unexpected symptomatology are not fit factors to  
be put in the scales for the reasons that virtually  
every expert conceded.

- - - - -





F/RD/ko

1  
2 THE COMMISSIONER: They don't establish  
3 it, but if they weren't there, if they weren't there  
4 then we could eliminate the suspicion.

5 MR. SCOTT: No. It is like saying if  
6 they didn't die.

7 THE COMMISSIONER: No, no.

8 MR. SCOTT: If they didn't die we  
9 conclude that they weren't poisoned with digoxin and  
10 even I would conclude that.

11 THE COMMISSIONER: Children, you see,  
12 the children who die in the ordinary course without  
13 any of these symptoms you can draw the inference that  
14 they would likely not. That is, as I understand it,  
15 is all that Mr. Lamek has been saying. The fact that  
16 those symptoms are there does not permit you -- if you  
17 symptoms being there you cannot eliminate the digoxin  
18 intoxication. If you want to go at it one way. Some  
19 people will go at it, of course, trying to find out  
20 whether they died of natural causes and some people  
21 may go at it trying to prove they died of digoxin  
22 intoxication. If you haven't the symptoms that are  
23 consistent with digoxin intoxication then you can  
24 eliminate that as a cause and that is what Mr. Lamek  
25 did with several of the children. Those symptoms  
simply were not there.





1  
F 2 2 MR. SCOTT: No. He is not using that  
3 merely to eliminate that as a cause, he is using it --

4 THE COMMISSIONER: That is true.

5 MR. SCOTT: -- to found a cause. I  
6 am going to be saying to you at the end, sir,  
7 you accept the limits of scientific knowledge, as we  
8 must, there are two factors: one legitimate in my  
9 respectful submission and one, with the greatest  
10 respect, lawyerish in the other, that you can look at.  
11 The first is evidence of digoxin in the system and I  
12 will saying to you that there are six babies, in which  
13 there is evidence, upon which you can found the  
14 conclusion, whether you will or not, for which Mr.  
15 Lamek contends.

16 THE COMMISSIONER: Bearing in mind  
17 that the others, they could not and the height of the  
18 art, the state of the art is such that you could not  
19 find any toxicological evidence in the others. You  
20 say, therefore, we cannot find those children died?

21 MR. SCOTT: No, you cannot draw a  
22 conclusion on any data that relates to the babies.

23 Now, Mr. Lamek says that you can draw  
24 a conclusion in the following circumstances: if you  
25 look at the last baby and conclude that that baby was  
the victim of foul play then you can take the statistics







F 3

1  
2 and apply the statistic elevated death level, the  
3 presence of a murderer, and that will lead you to draw  
4 conclusions in babies 1, 2, 3, 4 and 5. That, in my  
5 respectful submission, is, if you feel obliged to make  
6 an answer to all unanswerable questions, that is one  
7 rationale for going about it, but in my respectful  
8 submission that does not give you the assurance that  
9 you require, because we must recognize that even  
10 though you were to draw a conclusion about Baby Cook,  
11 as I think you could on this evidence, you might be  
12 wrong. That isn't to say that I can say that you are  
13 wrong, but we all must hold that possibility and you  
14 wouldn't want to use a conclusion in one case to found  
15 conclusions in others that are not warranted. This  
16 report is to put an end to that kind of suspicion-  
17 making and to say to the public, look, this is what  
18 we know.

17 There is a lot we don't know and there  
18 always will be and we are sorry it took so long, but  
19 you wanted to find out what we could find out and what  
20 we knew.

21 THE COMMISSIONER: Baby Cook is such  
22 an exceptional case, because on the 21st of March when  
23 he came into the hospital, by that time already there  
24 were deep suspicions that something was wrong.  
25





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1  
2 MR. SCOTT: Yes.

3 THE COMMISSIONER: And the digoxin was  
4 looked upon as the culprit and there even was some  
5 thought of a murderer being loose at the time. There  
6 would never be another occasion. The circumstances  
7 just certainly couldn't have existed more favourably  
8 to discovering a foul death than that. That is why  
9 they were able to do it with that.

10 Now, have I been asked to find out about  
11 the others? I can't expect those ~~were~~ perfect  
12 conditions.

13 MR. SCOTT: And you haven't got them.

14 THE COMMISSIONER: No and I certainly  
15 haven't got them.

16 MR. SCOTT: Poor Baby Cook in these  
17 circumstances provides, by the nature of the  
18 suspicions, by the nature of the steps that were taken  
19 by the staff, provides fortuitously, a horrible comment  
20 though it is to make, fortuitously provides the answer  
21 that you need, that you may need to know about Baby  
22 Cook. What use do you make of that? You see, the next  
23 formula is to be a statistician and say, well, if there  
24 should have on an average year been five deaths in  
25 this period or 10 deaths, therefore I am going to use  
this fact to draw conclusions about those other babies.





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THE COMMISSIONER: We do this all the time. People do it. That is what epidemiology is about.

MR. SCOTT: The epidemiologists haven't done it.

THE COMMISSIONER: Well --

MR. SCOTT: People may be asking you to do it, but the epidemiologists haven't done it.

THE COMMISSIONER: They didn't say that.

MR. SCOTT: They didn't say that. Why didn't they say it? Because it isn't logical.

THE COMMISSIONER: They said they were not pointing the finger at anyone, but it is impossible to read the Atlanta Report without reaching the conclusion that they thought that there was, first of all, that there were a lot of untoward deaths and that there was a murderer or murderers loose.

MR. SCOTT: I accept that. I accept both points but none of that enables you to say that Baby X died of digoxin toxicity.

THE COMMISSIONER: Well, if I were --

MR. SCOTT: -- or that Baby Y didn't. Maybe you could say that Baby Y didn't if there is some particular facts.







1  
2 THE COMMISSIONER: Dr. Hastreiter said  
3 himself that the only certain proof, and even then you  
4 can't be absolutely certain of digoxin toxicity, is  
5 the reading in the blood. That is what it is. We  
6 haven't got the reading of the blood, therefore, I  
7 can't give you the certain proof, but surely aren't  
8 all these statistics always analogies between Cook, and  
9 if you like, Miller, Pacsai and the rest and Lombardo  
10 and all the other children, and Belanger, that were  
11 found was digoxin in their blood, don't they lead us  
12 to some suspicion about Woodcock, Dawson and  
13 Velasquez?

14 MR. SCOTT: Let's take an example so I  
15 won't be offensive to any parents or the memory of any  
16 deceased child. Let's take a baby who I think we all  
17 agreed probably was not killed by digoxin. Floryn?

18 THE COMMISSIONER: David Leith.

19 MR. SCOTT: All right. The question  
20 here it seems to me is are you able to say that Leith,  
21 on an assured level, say to the parents, the relatives,  
22 the community in which that baby lived, that that baby  
23 died of digoxin poisoning on a reasonable standard of  
24 assurance?

25 THE COMMISSIONER: Certainly can't, no.

MR. SCOTT: No, but taking it as an





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1  
2 example.

3 THE COMMISSIONER: Yes.

4 MR. SCOTT: Or are you really saying,  
5 well, it is probable that some other babies died and  
6 if I have got to pick, if we are picking 15 it is  
7 probably this 15. That is not what this exercise is  
8 designed to do. This exercise, in my respectful  
9 submission, and the Attorney General makes no bones  
10 about it in his statement, is designed to parallel  
11 the kind of coroner's inquest. You cannot make any  
12 determinations that are civilly or criminally binding,  
13 but these parents have a right to know if there is  
14 evidence which entitles you to conclude how their baby  
15 died, what their baby died of and all I am saying  
16 that as lawyers, looking at it, you look for evidence  
17 that points in that direction, not in this direction,  
18 and to pile on a whole lot of evidence that points in  
19 neither direction or in both, doesn't assist you.

20 Now, if the Commission's function be  
21 simply to aggravate suspicions in the sense of saying,  
22 on the basis of the Atlanta Report, that we believe a  
23 whole lot of babies may have died of digoxin toxicity,  
24 we didn't need, with the greatest of respect, the  
25 Royal Commission to tell us that, the Atlanta Report  
was available to say that.





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2 What we needed here was a finding by  
3 the Commissioner that in the case of this baby the  
4 evidence is clear and in the case of this baby the  
5 evidence is not clear and the fact that we have better  
6 evidence in some cases than in others, and perhaps the  
7 best evidence in Cook and the worst evidence in some  
8 other case, doesn't make the job easier, but it  
9 dictates the answer that you have to come to, but we  
10 have been through this.

11 Is this the time?

12 THE COMMISSIONER: Oh, yes. We will  
13 take 20 minutes.

14 --- Short recess  
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2 --- Upon Resuming.

3 MR. SCOTT: Mr. Commissioner, when  
4 I was submitting earlier the conclusion that a  
5 death was sudden or unexpected was not a reliable  
6 indication which pointed either to foul play or  
7 to innocent cause, I should have brought to your  
8 attention proof of that proposition.

9 In three deaths that Mr. Lamek, in  
10 his submissions, concludes are without suspicion,  
11 indeed I think even without nagging suspicion,  
12 Perreault, Heyworth and Murphy, in each of those  
13 cases he went to considerable lengths to draw from  
14 Dr. Rowe the conclusion that the death was sudden  
15 or unexpected. If you can look at, for example,  
16 the case of Baby Perreault, Volume 12, beginning  
17 at page 2101; the case of Baby Heyworth, Volume 14,  
18 at page 2374; and the case of Baby Murphy at Volume 14,  
19 at page 2354; I'm sorry, he wasn't a baby, the boy  
20 Murphy, you will find that evidence.

21 What I say is that if the suddenness of  
22 the arrest event is not a significant factor in those  
23 cases, it is difficult to see how it can be vested  
24 with significance when it occurs in other cases.

25 Now I simply put the proposition to  
you again to make my submission, that we must be very





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careful to assure that the evidence with which we are concerned points in the direction of the conclusion that we are obtaining, and is not neutral evidence, and the suddenness or unexpectedness of the cardiac arrest, in my respectful submission, is neutral evidence that can have no significant bearing on the task that you are obliged to fulfill.

THE COMMISSIONER: Well, all right, did you say Perreault was a sudden death?

MR. SCOTT: Yes. At page - there is a considerable exchange in which at page 2103 at line 15, Dr. Rowe says:

" It is certainly sudden. "

He says earlier:

" So that the deterioration appeared there to be rapid. The sudden change in the condition appeared to be rapid. "

Now you are --

THE COMMISSIONER: All of these children, if you are just taking sudden as suddenly, because that is the only thing, because I guess deaths generally are sudden I suppose on anyone. Certainly it was not unexpected, it was expected, the death was expected some 15 days before in the





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1  
2 case of Perreault, and certainly in the case of  
3 Murphy and Heyworth it was expected.

4 MR. SCOTT: Well then that is to  
5 say that you are going to discount suddenness as  
6 a criteria, or as evidence.

7 THE COMMISSIONER: Well --

8 MR. SCOTT: If you do, then I understand  
9 what the standards are.

10 THE COMMISSIONER: Well, in the case  
11 of Leith, wasn't Leith sudden?

12 MR. SCOTT: Yes, Mr. Commissioner. The  
13 problem that I have, let's leave other considerations  
14 aside for the moment and just talk about suddenness  
15 and unexpected. If suddenness and unexpectedness  
16 is going to be evidence pointing in the direction of  
17 foul play, in one case suddenness and unexpectedness  
18 as a characteristic must point to suddenness, to  
19 foul play in all cases.

20 Now there may be other factors but if  
21 the factor that you are focussing on for the moment,  
22 that you are putting in the scales is the suddenness,  
23 how do you explain the cases in which suddenness  
24 was a factor and in which Mr. Lamek says are natural  
25 causes.

THE COMMISSIONER: No, but digoxin







1  
2 toxicity carries with it, I am told, Dr. Rowe and  
3 everybody else says there is a sudden arrest, that  
4 is what happens. Now, if it doesn't happen you  
5 can eliminate it.

6 MR. SCOTT: Yes.

7 THE COMMISSIONER: Now if it does  
8 happen, that is not specific because it can be  
9 something else. We can, as you said before, we  
10 can throw it out.

11 MR. SCOTT: But we are not talking  
12 about eliminating now.

13 THE COMMISSIONER: No.

14 MR. SCOTT: We are talking about those  
15 cases in which Mr. Lamek said the suddenness and  
16 unexpectedness was one of two or three factors that  
17 should lead you to conclude that the deaths were  
18 suspicious at various levels. I am saying as a  
19 logical exercise that doesn't have the virtue of  
20 logic.

21 THE COMMISSIONER: Well I will agree,  
22 if I were to say that by itself it adds and it  
23 does - you say even with other things it adds  
24 nothing to it. What it adds, it adds this negative  
25 value that you can't discount digoxin toxicity,  
as long as it is sudden, and particularly when it





1  
2 is unexpected.

3 MR. SCOTT: I say that by itself  
4 it doesn't point in either direction, it is a  
5 natural phenomena.

6 THE COMMISSIONER: Okay.

7 MR. SCOTT: Now Mr. Lamek couples  
8 it with some other facts. If those other facts are  
9 themselves neutral, zero plus zero does not make five.  
10 In other words two neutral facts, or three neutral  
11 facts are no better in making an assured determination  
12 than one neutral fact and that therefore the difficult  
13 problem, and why your task is a difficult one is  
14 that you are going to have to, in my respectful  
15 submission, grapple with the extent to which these  
16 factors are evidence from which you can conclude.  
17 It is not simple. You know, if it was everybody  
18 would be delighted, it is a terribly difficult complex  
19 scientific problem.

20 Now there is some help for you in a  
21 certain number of cases, but there is not in the  
22 vast majority of the cases.

23 Now one of the other factors that  
24 Mr. Lamek relies on of course is that in a number of  
25 the cases is the manner of the cardiac arrest, that  
is its characteristics apart from being sudden or





1  
2 unexpected; bradycardia and all the rest of it  
3 that Dr. Mirkin described. Dr. Rowe dealt with  
4 this, as I indicated, in Volume 19. The heart of  
5 his evidence and there is no dispute about it as  
6 I understand it, is that what is crucial to an  
7 understanding of the cause of death is a judgement  
8 of the underlying factors which may produce the  
9 cardiac arrest, and therefore when you look for the  
10 possible underlying causes of the death, what caused  
11 the heart of the baby to stop beating, there are some  
12 14 possible known clinical variables, in patients,  
13 each of which may lead to a cardiac arrest, and  
14 death, and some, but not all of which may be revealed  
15 in a pathological examination. I have to take you  
16 through them quickly.

17 A cardiac arrest resulting from heart  
18 failure caused by an abnormal heart will be characterized  
19 by bradycardia, vomiting, sudden onset, ventricular  
20 fibrillation, arrhythmias, and shallow respiration.

21 A cardiac arrest caused by heart failure  
22 as a result of an infected heart muscle demonstrates  
23 substantially the same way.

24 A cardiac arrest caused by hypoxia,  
25 shortage of oxygen, will be characterized by  
bradycardia, vomiting, sudden onset, ventricular







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2 fibrillation, arrhythmias and shallow respiration.

3 If sepsis is the cause of death,  
4 bradycardia, vomiting, and sudden onset will usually  
5 accompany the terminal events.

6 It is also possible as the evidence  
7 reveals that ventricular fibrillation, arrhythmias  
8 and shallow respiration will be found. I don't  
9 propose to take you through, because I know you  
10 will remember the evidence that Dr. Rowe gave and  
11 which was confirmed by a number of experts. Now,  
12 what is the upshot of that? The upshot of that is  
13 that taken by itself the presence of bradycardia;  
14 the presence of vomiting; the presence of sudden  
15 onset; the presence of ventricular fibrillation;  
16 the presence even of arrhythmias and shallow respiration  
17 do not point in one direction or the other. Those  
18 phenomenon according to medical science are neutral  
19 facts.

20 Now, if suddenness is the neutral fact,  
21 and if these characteristics are a neutral facts,  
22 two neutral facts don't point you in one direction  
23 rather than the other. That of course is why  
24 as I said Dr. Nadas and the CDC found so many babies  
25 to have died in conditions consistent with their  
clinical condition and indeed conditions consistent





1  
2 with digoxin toxicity, because the symptoms, the  
3 dying signs are substantially the same in both  
4 cases.

5 It is my respectful submission that  
6 any attempt to try and separate them out in these  
7 cases is not going to be useful in the determination  
8 you have to make. The only prudent approach for  
9 this Commission is again to examine the toxicological  
10 data in those cases where it exists.

11 Now as Dr. Rowe testified many of the  
12 abnormalities that he described in the 14 can lead  
13 to cardiac arrest, even though the child sick in  
14 hospital may have a normal heart, the presence of  
15 an abnormal heart is not a pre-condition for many  
16 of those abnormalities, I'm sorry, many of those  
17 modes of arrest.

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But where the child in question is a compromised baby with a congenital heart disease as was the case with a majority of these babies under investigation the additional factors put them at an increased risk of death. He put before you Exhibit 126, a publication reporting on the New England Regional Infant Cardiac Program which found certain factors present in children who were said to be at risk. These were explored by him with questioning from a number of Counsel in Volume 2, page 3960 and following. The anatomical condition of the child and the severity of the lesion is one factor placing a child at increased risk. Extra cardiac malformations or complications is another factor. The age of the child and low birth weight also increases the risk. Prematurity is a factor. A child who has failed to thrive from birth also faces increased risk as do children who have had surgery. In the Volume which we have now had copied, I'm not quite sure at whose expense, and which each Counsel has, you will find in the summary of Dr. Rowe's evidence on each of the babies reference where it exists to each of these factors.

There is also evidence in the New England study that there is a higher risk of mortality in patients who are being operated on under the age







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2 of two months. In particular the study found that  
3 between 35 and 40% of the children studied died within the  
4 first year of their life. Clearly any child with  
5 a congenital heart disease who does survive to one  
6 year of life has a better prognosis and is less  
7 likely to die suddenly or unexpectedly. The same  
8 cannot be said for the very young, highly compromised  
9 infants with whom, in many cases, we are dealing. It  
10 is because of this profile that in the Hospital during  
11 the period under investigation the deaths were  
12 viewed from a clinical perspective because the clinical  
13 perspective is the best vantage point from which to  
14 judge the cause of death with, where appropriate,  
15 pathological and other aids. With very few  
16 exceptions no death was so out of keeping with the clinical  
17 explanation as to be highly suspect. I think I  
18 can show later even in retrospect the clinicians  
19 and the independent experts accept that the clinical  
20 status of these children may explain their deaths.  
21 The children under investigation with only three  
22 exceptions, Woodcock, Hines and Pacsai had severely  
23 compromised anatomical hearts. Hines and Pacsai  
24 were believe to have compromised conduction systems.  
25 In addition all had a number of clinical variables  
which could lead to sudden death demonstrated by





1  
2 the familiar terminal events of ventricular  
3 fibrillation, bradycardia, arrhythmia, shallow  
4 respiration, seizures and vomiting.

5 Exhibit 158A examines the babies with  
6 which you are concerned individually and indicates  
7 that these children had compromising factors each  
8 of which could have led to death in the manner  
9 described as being indicative of digoxin toxicity.  
10 Many had in excess of four or five of these variables  
11 in combination. You say, what has all that got to  
12 do with me? What all that has to do with you is  
13 to emphasize the difficulty of the assessment that  
14 you have to make. This report, I know, will satisfy  
15 that parents that all that has known has been known,  
16 recorded and decided, and I know it will satisfy  
17 the doctors and the nurses. It will be a difficult,  
18 difficult task, but you cannot deal with the problem  
19 unless you take account of these factors, and to  
20 refer to a statistical analysis not designed to  
21 prove the question you have to answer is really in  
22 the end not going to help you with the answer and  
23 is not going to justify your expectations.

24 Dr. Cutz in Volume 47 beginning at  
25 page 3777 emphasized that with respect to the 14  
causes of death each of which was possible for one





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2 of these infants discussed by Dr. Rowe, that evidence  
3 of those would be seen at autopsy in only some  
4 instances. He told you that for example pump  
5 failure as a result of anatomical defect would be  
6 observed at autopsy and there would be other  
7 evidence of pump failure in other organs such as  
8 liver, lungs, kidneys, etc. He went on to say that  
9 hypoxia, a common method of dying in young children,  
10 would be revealed but only if such spells had been  
11 occurring for more than 24 hours before death. If  
12 not, there might be no pathological indication at  
13 autopsy. If sepsis was the underlying cause of  
14 death, there might again be tissue reaction but it  
15 takes time for those changes to occur and overwhelming  
16 sepsis of a short duration would not be observed  
17 at autopsy. He went on to deal with respiratory  
18 illnesses which might or might not be observed,  
19 temperature instability and so on.

20 The point here takes us back to the  
21 pathological point. Mr. Lamek says you can  
22 take account of the fact that some of the pathologists  
23 reports were not able to disclose the cause of death.  
24 The pathologist said that but Mr. Lamek says that  
25 you can take account of that. In what way? You  
can take account of that to escalate your suspicions.







1  
2 Dr. Cutz, uncontradicted, says there are many  
3 methods of dying common to small babies in a  
4 cardiac ward where there will be pathological evidence.  
5 In particular Dr. Cutz noted and you will have a  
6 note of the evidence and I don't have to go through  
7 it all, if there is a conduction failure the  
8 pathologist without an elaborate study cannot find  
9 any cause of death that is related to a conduction  
10 failure. One was contemplated in the case of the  
11 Hines child but those studies are long and elaborate  
12 but necessary if that cause of death is to be  
13 included or excluded. Otherwise evidence of it is  
14 not present at autopsy. The same with acidosis,  
15 there would be nothing at autopsy to either confirm  
16 or refute the clinicians' judgement that acidosis  
17 caused or contributed to the cause of death of the  
18 child. The same with apnea, except that a detailed  
19 examination of the brain may show changes in the  
20 area which controls respiration if the apnea has  
21 been occurring, according to Dr. Cutz, Volume 47,  
22 page 395, for some weeks. He said that apnea assigned  
23 by clinicians as a cause of death in young babies  
24 with cardiac problems is not observed at  
25 autopsy in 50% of the cases.

What Mr. Lamek said, you will have a





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2 note of his evidence, is where the autopsy findings  
3 in the 36 cases under investigation had pinpointed  
4 no particular cause of death, the balance in the  
5 case should shift to a determination that digoxin  
6 was involved in their deaths. Yet the testimony  
7 of the experts makes clear that many factors may  
8 lead to death and yet not be detectable at autopsy.  
9 Again it is clear that as scientists, pathologists  
10 look for evidence before they ascribe a known cause  
11 of death. Frequently the certainty which would be  
12 sought by lawyers is not present in the medical  
13 world. The evidence for many reasons simply does  
14 not present itself.

15 It is also notable at this juncture  
16 to indicate digoxin poisoning which Mr. Lamek assigns  
17 as the cause in some of the deaths and which may  
18 be a cause in some of the deaths does not show at  
19 autopsy. If it is argued that apnea is not the cause  
20 and Dr. Rowe or the clinicians are wrong because in  
21 part it was not disclosed at autopsy, the same argument  
22 could be turned around in exactly the same meaningless  
23 sense - digoxin was not disclosed in autopsy therefore  
24 is the cause. For that you have Dr. Becker's evidence  
25 at Volume 38, beginning at page 7723.

Therefore, Mr. Commissioner, I submit to





1  
2 you with the greatest respect that the facts that  
3 the deaths were sudden or unexpected, the fact that  
4 it was consistent with digoxin toxicity, the fact  
5 that resuscitation failures were high, if they  
6 were, the fact that death was accompanied by symptoms  
7 of bradycardia, high respiratory rates, seizures,  
8 vomiting and arrhythmias and the fact that the  
9 autopsy failed to demonstrate the cause of death are  
10 all neutral non-factors. In some cases you have  
11 one and it leads to no conclusion; to have five does  
12 not help you because five zeros still equal zero.  
13 All of them are uncertain and unreliable guideposts  
14 to the judgement you have to make and any real  
15 assistance has to be found in the toxicological data  
16 where it exists. Where it does not exist, if you  
17 have noted, because it is not available, through  
18 nobody's fault, judgment simply cannot be safely  
19 made because you then begin to enter into the world  
20 not of science and logic where we might be at home  
21 on the evidence but into the world of statistical  
22 analysis.

23 That brings me to what is really the  
24 heart of Mr. Lamek's submission. I agree with some  
25 of his conclusions about individual babies to which  
I will come in a moment, but in my respectful submission







1  
2 his process may lead you so far astray that though  
3 you may come to the right result in a number of  
4 cases it will be by a process that will be faulty.  
5 He asks you really to draw a conclusion first in  
6 Cook and then in effect presume that all preceeding  
7 deaths are suspicious. He argues that once there  
8 is a conclusion that any one child died as a result  
9 of digoxin intoxication the balance tips and there  
must be suspicion about the others.

10 As fate would have it, the baby that  
11 tips the balance in Mr. Lamek's view is the last  
12 baby in the nine month sequence who died and he has  
13 an advantage in making that submission that is not  
14 available to the doctors or the Hospital who had no  
15 knowledge of Cook until the end; but that is an  
16 advantage he is entitled to have because we are not  
17 concerned in this inquiry about whether the clinicians  
18 were right in March or September or January, we are  
19 concerned about what, in fact, the facts reveal about  
20 cause of death. That is an advantage he is entitled  
to have.

21 The point is, that once you make a  
22 conclusion about Cook the balance tips and there  
23 are two kinds of evidence. First he says you can  
24 review the death of a particular child, the clinical  
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2 course, the nature of terminal events and the reaction  
3 of the staff to the death, if they were surprised  
4 or shocked. The second thing he says is that you  
5 can look at what he calls the nature of common  
6 patterns or, his phrase, common threads running through  
7 the deaths; the failure of resuscitation and the  
8 remarkable frequency of sudden deaths. He asks you  
9 to conclude with respect to some of the babies that  
10 it is inescapable, his word, that an number of  
11 these babies were deliberately killed by overdoses  
12 of digoxin. He suggests, and I agree, that the  
13 question for which we may never have an answer is  
14 how many of these children died in such a fashion.  
15 He asks you to conclude however that the vast  
16 majority of these children died from digoxin involve-  
17 ment because of the finding as he says that one  
18 irrefutably did; and that is the point with which  
19 we take issue.  
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In my respectful submission and perhaps I am repeating myself, if your report is to stand as a record in this case you have got to err on the side of caution.

In the absence of clear and compelling evidence, particularly toxicological evidence, it is difficult to determine whose cause will be advanced by including as many babies as possible in the suspicious probably murder category as he does. Certainly that, in my respectful submission, will not serve the interests of the public or the interests of the parents.

In addition, the confidence and faith of the staff committed to saving the lives of infants is not served by increasing where there is not a firm evidentiary foundation, the likelihood of probable murder.

Dedication and determination of a staff that is devoted for caring for sick and dying infants can only be undermined by making determinations that are not firmly founded on the evidence.

There really is a difference of focus I think between the position Mr. Lamek takes and the position we take. You have to decide the position from which you begin to classify the deaths. Either







1 you start at the natural causes end of the spectrum  
2 and move away from this position only in the cases  
3 where you have been presented with clear and compelling  
4 evidence, that the death was due to something other  
5 than natural causes -- that is the position I take --  
6 or you start with the assumption that, because of  
7 Cook, all of these deaths were suspicious probable  
8 murder and eliminate from the list only those deaths  
9 in which there is a clear and compelling consensus  
10 among experts that the deaths should be considered as  
11 natural.

11 If you tried to analyse the foundation  
12 of Mr. Lamek's effort to categorize these babies, I  
13 think it will be revealed -- I haven't quite completed  
14 the exercise -- but if there is any expert who raises  
15 a possibility, even though the weight of the expert  
16 testimony is against him --

17 THE COMMISSIONER: I don't think he  
18 ever went to possibility. I think he may though have  
19 gone as far as probability. If any expert believes that  
20 the child died of digoxin toxicity perhaps that is  
21 enough to make it a suspicious death.

22 MR. SCOTT: The result of that is  
23 there is no rationale for it. Sometimes he accepts  
24 Dr. Hastreiter and sometimes he rejects Dr. Hastreiter  
25 on a death that occurred right the next week.





1  
2 THE COMMISSIONER: That is the judicial  
3 process. We are entitled to do that if we want to.

4 MR. SCOTT: You are entitled, but in  
5 my respectful submission, you don't want to, because  
6 what you have got to do is erect a rational foundation  
7 and there is one for your findings. I mean, I can't  
8 emphasize it too strongly, sir. You are not a  
9 Delphic Oracle. No one expects you to be right, but  
10 everybody expects, knows that you will apply yourself  
11 to the development of some standards against which the  
12 case is to be judged. It is to be judged. I mean  
13 this report is important.

14 THE COMMISSIONER: I can assure you  
15 that whatever I will do I will try to justify it.  
16 It may not be justifiable, but I will certainly do  
17 my best to justify it by giving the reasons.

18 The thing that concerns me is that  
19 you are saying that I should err on the side of caution.  
20 I have been asked to find the cause of death. Why  
21 should I err on any side? Why should I err on the  
22 side of caution or the side of boldness? Why shouldn't  
23 it be my honest opinion? What is wrong with that?  
24 It may do a lot of harm to people, but they have asked  
25 me to do it. This is what I have been faced with in  
this Commission with all along.





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MR. SCOTT: But why do you think they asked you to hear the evidence? You might have been asked to give your opinion.

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THE COMMISSIONER: That is right, and I hear the evidence and surely don't I decide the best I can and if it doesn't please people and it causes harm --

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MR. SCOTT: I don't ask you to please people and I don't ask you to be over-awed by the prospect of causing harm, but with the greatest respect, no one is interested in your opinion, because that could have been canvassed without the necessity of hearing any evidence.

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THE COMMISSIONER: Not quite. I think the opinion after a year is a little better than the opinion, just guessing at the beginning, read the Globe and Mail.

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MR. SCOTT: It is your opinion on the evidence.

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THE COMMISSIONER: That is right.

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MR. SCOTT: So what you have to do is you have to evaluate that evidence. To say now, I have been sitting here for a year and I have heard it all, but I guess this, this, this is not going to provide the foundation which alone will justify this







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2 report.

3 I say you should err on the side of  
4 caution, because you are engaged, willy nilly you  
5 didn't ask for it. We didn't ask to be here, and what  
6 is really a scientific exercise, in which there is in  
7 many cases a division of opinion. What Mr. Lamek says,  
8 if I read his analysis correctly is that when one of  
9 four, three or four or five experts - it varies from  
10 case to case - says I think it may be probably murder,  
11 then that puts it into slot A. That is a mechanical  
12 formulation.

*Crash!*

13 THE COMMISSIONER: It is only if the  
14 reasons given by the witness makes sense. This is  
15 what the judicial process is about. If the expert  
16 comes in and he gives reasons and he reaches a  
17 conclusion and you don't think much of his reasons,  
18 therefore you don't think much of his conclusion.  
19 If, on the other hand his reasons makes sense and he  
20 stands up well under cross-examination -- I have been  
21 doing this for years. Maybe it has been wrong, but  
22 this is what I have been doing and I will believe one  
23 of them and I won't believe another. It may well work  
24 in favour of your argument, because I may well believe  
25 one of the experts who is on the side of caution,  
as opposed to one of the ones who was prepared to





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find murder under every bed.

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MR. SCOTT: I begin with the proposition, and I am repeating myself from yesterday, that no expert witness came from afar to this Commission to pull the wool over anybody's eyes. They are all truly distinguished practitioners of their science. They all came in an effort to be as helpful as their knowledge and science permitted them to be and all I say, unless the experts say that is murder or that is digoxin involvement, how can you discount the one who says that I have grave doubt about it? In that case you have to say that it is not proven or you have to do what Mr. Lamek does, which is to ask you to accept Dr. Hastreiter in one case and reject him, as incredible in another case; to accept Dr. Kauffman in one case, but dealing with the next baby say, well, we will just put aside Dr. Kauffman, we weren't impressed by him when he dealt with Baby B.

THE COMMISSIONER: It is inconsistent, but it is still permitted. It is still part of the judicial process. If I don't think that Dr. Kauffman gave enough consideration to certain factors in one thing and gave a lot of consideration to something else I am entitled to say that I believe him in A and I don't believe him in B, but I will accept him in A, I won't





1  
2 accept him in B.

3 MR. SCOTT: You are entitled and there  
4 is no appeal. In my respectful submission in a case  
5 like this --

6 THE COMMISSIONER: I am entitled and  
7 I trust that I will not -- if I decide that one witness  
8 is essentially credible I will not reject his evidence  
9 on some matter unless there is good reason for it.  
10 If I were a jury I wouldn't have to give reasons. As  
11 I am not a jury I will have to give reasons and I  
12 will give reasons, however, your point.

13 MR. SCOTT: You have my point.

14 THE COMMISSIONER: I have your point  
15 on that. It is a good one. I don't promise to accept  
16 it, but it is a good one. It is like Dr. Kauffman's  
17 evidence, I don't have to accept it.

18 MR. SCOTT: Well, then, Mr. Lamek then  
19 goes on to deal with the second kind of evidence and  
20 the first kind of evidence he has categorized I have  
21 no quarrel with it. I say a number of the factors he  
22 deals with are neutral, but the first kind of evidence,  
23 which is primarily toxicological, I have no quarrel  
24 with.

25 Then he goes on to deal with a second  
kind of evidence. He says and I am quoting:







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2 "The second kind of evidence is the  
3 evidence as to patterns and common  
4 threads running through the deaths.  
5 At the time of the onset of critical  
6 symptoms of so many of these children,  
7 the depressing failure rate of  
8 resuscitation efforts during the  
9 epidemic period, the observable  
10 associations between Hospital personnel  
11 and deaths, the remarkable frequency  
12 of sudden, precipitated and  
13 irreversible decline <sup>to</sup> of cardiac  
14 arrest and death."

15 We say that that is not a permissible approach, because  
16 it, in effect, is circular.

17 Mr. Ortved, I understand, will deal  
18 in some detail, with the patterns, but let me give you  
19 what assistance I can in dealing with our proposition  
20 here.

21 Mr. Lamek uses the development of a  
22 pattern to suggest that something untoward was occurring  
23 on the Wards 4A and 4B. pattern culminates in  
24 the death of Cook and Mr. Lamek suggests, elevates  
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2 the Cook death to one of suspicion. It is the pattern,  
3 initially, that makes the Cook death suspicious.

4 By Mr. Lamek's own argument, the Cook child was so  
5 seriously compromised clinically that his death, had  
6 it not occurred in the context of an elevated death  
7 level, could not have been said to be sudden or  
8 unexpected.

9 Having used the pattern to help him  
10 establish the suspicions surrounding the death of  
11 Baby Cook he then takes the next step.

12 THE COMMISSIONER: I see what you are  
13 saying and I see what you are saying in circular.  
14 I don't think that is what he did. I thought he took from  
15 Cook's pleadings the fact that Cook wasn't supposed  
16 to be on digoxin at all and from that determined that  
17 Cook was poisoned by digoxin. Then having done that  
18 he examined the circumstances of Cook and he compared  
19 those circumstances with other babies, some of whom had  
20 digoxin evidence and some of whom didn't. He reached  
21 a conclusion. That is perhaps not precisely what he  
22 did, that is what I was told he was trying to do.

23 MR. SCOTT: I don't think we are very  
24 far apart in what he did, but I still say it is  
25 circular.

Yesterday I tried to persuade you that





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2 patterns are not likely to be of assistance and, in  
3 particular, we suggested that any pattern from which  
4 you could draw any conclusion would have to await  
5 your determination of the cause of death of the  
6 children, that you can't assume a pattern, use it to  
7 prove a fact and then use that, those facts so proven,  
8 to confirm the pattern.

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11 Your determination, as to which babies  
12 died on an individual basis may well produce a pattern,  
13 but a pre-existing notion of what the pattern is, is  
14 not going to be of any assistance to you.

15 If you return for a moment to Mr.  
16 Lamek's classification of the babies. At the end of  
17 his argument he indicated to you that there were 11  
18 babies, on whom he had no toxicological information.  
19 These were babies Taylor, Hoos, Turner, Shrum.  
20 He has listed them I think in the last two categories.  
21 Shrum, Monteith, Velasquez, McKeil, Adamo, MacDonald,  
22 Gosselin and Fazio. They are the babies that are  
23 found in his categories which I numbered 6 and 7.  
24 He said that at Volume 153 at page 824.

25 Now, he took those 11 babies and he  
urged you, on the basis of their terminal events,  
to consider that six of them had some level of suspicion  
and five he said that the only evidence, which he







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wasn't going to ask you to act on, was the presence of the nursing team.

I think you will remember that of the six he said there is something suspicious in the way they died and with five there is nothing probative that you can rely on.

Now, of those 11 babies --

THE COMMISSIONER: There is nothing but the circumstantial evidence is the way he put it.

MR. SCOTT: And the circumstantial evidence means, not the manner of their dying, it means the ward and the shift.

THE COMMISSIONER: Certainly some of these five were, their manner of death was classified as consistent with digoxin intoxication, but Mr. Lamek found nothing else to go with it other than the circumstantial evidence, which was death in the presence of a particular team of nurses.

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MR. SCOTT: And there were of course lots of other babies whose deaths were consistent with clinical causes or digoxin intoxication.

THE COMMISSIONER: That's right.

MR. SCOTT: That factor points nowhere.

THE COMMISSIONER: That's right.

MR. SCOTT: So what he says is that his first category, Category 6 is a category where there is something in the manner of dying "sudden and unexpected", was the pattern of death, he finds some evidence there.

THE COMMISSIONER: Yes.

MR. SCOTT: In the seventh category he finds no evidence, what he calls the circumstantial evidence, and I understood him to mean by that their death on a particular ward at a particular time under the supervision of a particular shift.

Now of the 11 babies, you know, if you took those 11 babies and tried to make a pattern of them you have to look, because there is no toxicological evidence in any of them, to the expert evidence to determine the nature of the cause of death.

Now, Velasquez is a special case, because there is a medical dispute which he dealt with at some length with respect to





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2 the idiosyncratic reaction to the particular  
3 drug; but yet if you look for a pattern, for example  
4 in August, at the time of death, you note that Hoos,  
5 Turner and Monteith all died in the small hours of  
6 the morning on Ward 4A in the presence of the Trayner  
7 team, but yet each of them is judged to have been a  
8 natural death. The nature of the pattern doesn't  
9 assist you in reaching a conclusion as to how the  
10 children died. The only relevant evidence on those  
11 babies, and on the others, can be the position of the  
12 experts. So that when you look for a pattern it is  
13 not there. Now what there is, and I will be coming  
14 to it, is an elevated level of deaths and we concede  
15 that, we have had our own epidemiological study done  
16 and we accept CDC which says that. But if you are  
17 looking for a pattern, the common threads, in my  
18 respectful submission it simply is not there.

19 Now if you look, for example, if you  
20 accept the submissions of Mr. Lamek between the period  
21 July 31, 1980 and September 2, there are seven deaths.  
22 Of these he urged you to find there were natural deaths  
23 in five of the children, Hoos, Turner, Monteith, Murphy  
24 and Heyworth. He has noted that the evidence support-  
25 ing a suspicious death in Shrum is dubious and based  
only on Dr. Hastreiter's assertion that the heart







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block occurred some time after the catheterization. That baby does not fit the time pattern because he died at 8:00 p.m. How then does the pattern assist you? It doesn't assist you because the very pattern for which he contends in August - September, in that period, is a pattern of natural deaths. It is, therefore, fallacious to use a pattern established in the course of deaths found to be natural deaths to substantiate suspicions about deaths which may be more puzzling. It is just a process that has no logical virtue to it.

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That leads you to the question if you cannot rely on a pattern, you can rely on the fact that there is an elevated level, but you cannot rely on a pattern, because Mr. Lamek's own submissions discount the pattern. Because if the pattern existed as he says it did, he would not be making the submissions he is making to you on the particular deaths. Those submissions are inconsistent with the pattern on which he relies in dealing with the other cases, and that is why our major submission to you has been that in the act of deciding you have to make an effort to establish the standards by which you are going to judge the cases.

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If we look, for example, at Colleen





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2 Warner who died on March 7th at 3:45 in the morning.  
3 If you look at the so-called pattern, the time of her  
4 death is critically suspicious. The presence of the  
5 team is suspicious; the death on 4A is suspicious; yet  
6 Mr. Lamek has said ignore the pattern in Colleen  
7 Warner's case, digoxin involvement in that child is  
8 probably as a result of therapeutic administration.  
9 This in spite of the fact that Dr. Rose has testified  
10 that she checked the loading doses and those loading  
11 doses appeared appropriate. So even Mr. Lamek  
12 contending on the one hand for a pattern to show the  
13 likelihood of digoxin involvement is obliged to make  
14 exceptions to the pattern that illustrate the pattern  
15 is not there. The pattern, if there is one, will be  
16 illustrated when you make your findings as to what  
17 deaths on the weight of the expert evidence were  
18 digoxin oriented and which were not.

17 Now if we can go one stage further,  
18 with Baby Warner, because I think it illustrates, it  
19 is an illustration of the problem with which you are  
20 going to have to deal. If there was ever a baby whose  
21 death on the basis of the pattern should be judged  
22 suspicious, it is the death of Baby Warner. The critical  
23 month, the critical team, the critical hour, and if  
24 the pattern is going to be one of the standards that  
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you apply you have got to put Baby Warner into the suspicious categories.

THE COMMISSIONER: But there is a difference. You see what happened here is Baby Warner is not being put in the suspicious category because there are no other suspicious facts, there is nothing that establishes that Baby Warner died a natural death, that has not been proved either, but we don't put Baby Warner, and I am now speaking for Lamek, and not necessarily accepting Mr. Lamek --

MR. SCOTT: That is the way I would treat it.

THE COMMISSIONER: But that is, that is his argument, he can't say - he is not saying necessarily that Baby Warner died a natural death, that Baby Warner could conceivably have been poisoned. There is nothing in the circumstances of the death of that baby that definitely establishes that it died a natural death. We do have some very positive evidence in the case of Cook, because we have this unprescribed digoxin in his body. We have nothing like that insofar as Baby Warner is concerned. We have to look around and see if we can find anything else, we can't find anything else and therefore it is that we put that in the natural death category. It certainly doesn't







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please you the fact that he has done that, he has done that in the sense to satisfy the principle that we don't go guessing at somebody being murdered, we don't do that, there has to be some real basis for subscribing to that view. With Warner there isn't and therefore we put it in the natural death, and I thought you would like that.

MR. SCOTT: That is the problem. I don't part company with Mr. Lamek in the case of Cook, or indeed in his analysis of five or six of the cases where there is toxicological data. I get concerned because I want a level of assurance in the report about what he does when he has not got toxicological data. When he has it he and I make a similar submission to you. When he has not got it, then what does he do? He goes to other factors. I have been trying to analyze the factors he goes to "sudden and unexpected", the terminal events.

THE COMMISSIONER: The failure of the pathologist --

MR. SCOTT: The failure of the pathologist; the failure of the resuscitation effort.

THE COMMISSIONER: The surprise.

MR. SCOTT: The surprise. On analysis those are not, I am repeating myself, those are not





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factors that point in that direction. The last factor he goes to is, what does he call it --

THE COMMISSIONER: The circumstantial evidence.

MR. SCOTT: The circumstantial evidence, the ward, the team. Now all I am saying --

THE COMMISSIONER: And the frequency.

MR. SCOTT: All I am saying is, how does that become a corroborative fact. In my respectful submission it doesn't become a corroborative fact unless he is prepared to say, which he is not, that that is a standard that will excite suspicion in each case. Because what he has done is, he has said it doesn't excite suspicion in the following cases.

THE COMMISSIONER: He doesn't have to find it in all cases, I don't have to find it in all of these deaths because these children were in a hospital, they were sick and some of them were going to die. Now if all of the children were perfectly healthy, if there was absolutely nothing wrong with them at all, and if they all died the same hour with the same team and everything else then it would be illogical to say, he would have to say they all died from something. With these children you don't have to do that, some of them we know, they were all very





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2 sick, and some of them could and some of them couldn't,  
3 that is why we have had this inquiry, because the fact  
4 it was in a hospital.

5 MR. SCOTT: In my respectful submission,  
6 one is justified in an inquiry like this in referring  
7 to a pattern as probative of something. If there is  
8 a pattern, the characteristic of a pattern is its  
9 consistency. There ceases to be a pattern if it is  
10 not consistent, it then becomes two patterns, or three  
patterns, or a mix.

11 Now what I am saying is that Mr. Lamek  
12 having announced the pattern immediately destroys its  
13 characteristic as a pattern by deviating from it.  
14 Then all I say about that is that if he is obliged to  
15 do that, and he undoubtedly is, I mean I accept what  
16 he says, then he can't rely on the pattern. If he is  
17 going to rely on the pattern as probative in case X  
18 he can't say well I choose not to rely on the pattern  
19 in case Y, he is then not applying a principle that  
20 makes any sense. He is developing a make-weight for  
one case that is not applied to the other.

21 Now if you think - if he came and said  
22 there is a pattern which can be demonstrated, which is  
23 a real pattern, that would be one thing, but he doesn't  
24 say that, he says there is a pattern which I am going  
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to invoke in these cases but for those cases I do not  
rely on the pattern, it doesn't apply, and of course  
he doesn't rely on it in those very instances that the  
pattern is designed to account for: the ward; the  
nurse; the shift; and all the rest of it.

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Now all I am saying is that in my  
respectful submission that kind of observation is not  
a firm foundation for the kind of assured conclusion  
that we want you to draw and that we think you can draw  
in some of these cases and to overreach the determi-  
nation necessary by reference to those considerations,  
in my respectful submission, is not consistent with  
the kind of report that you will want to make. I  
wonder if this would be a convenient time, sir, to  
refuel?

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THE COMMISSIONER: Yes. Yes,  
Mr. Tobias?

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MR. TOBIAS: Mr. Commissioner, just  
before we break. It was my impression from the  
exchanges which took place earlier this week that we  
might be in the position where we had some time off  
tomorrow afternoon. I think you are aware of the fact  
that I and some of the other parents' Counsel want to  
address you on certain issues.

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THE COMMISSIONER: Yes.





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MR. TOBIAS: If it appears that in fact Mr. Ortved may be arguing tomorrow afternoon I am just wondering if it might be appropriate to sit a little later and set aside half an hour or so at some such time so we can address you on this concern?

THE COMMISSIONER: I think what he is now asking Mr. Ortved, he is really speaking to you, how long do you expect to be. If I shut up you would be finished sooner.

MR. SCOTT: No, no.

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MR. SCOTT: I have kept quiet for the last couple of weeks in order to have this exchange and I am grateful to you, Mr. Commissioner, for participating fully in it because it is so fundamental. It just has to be dealt with. I would feel very badly - I would rather that you had the time to put your problems to me, if I could help you than that I dealt with them.

THE COMMISSIONER: Assuming that I am going to do that, then --

MR. SCOTT: Then we are going to have a good time and we may not be able to satisfy my friend. I think I will be finished by lunch tomorrow, maybe the break.

THE COMMISSIONER: Mr. Ortved.

MR. ORTVED: My prognosis as to timing remains approximately the same as yesterday.

THE COMMISSIONER: A half a day. Do you want to put your proposition, whatever it is, tonight? Would that suit you better?

MR. TOBIAS: I was going to suggest that perhaps we set aside some time directly at 4:30 tomorrow and put the proposition at that time.

THE COMMISSIONER: All right. Well, not at 4:30 - if Mr. Ortved sits down I want you to







stand up.

MR. TOBIAS: No, no, we are prepared to go on as soon as he is finished, when Mr. Ortved sits down, but assuming that he is going to go over and take up some time on Monday, perhaps 4:30 would be a convenient time.

THE COMMISSIONER: All right, we will do that.

What is your position on Monday next, in case you find that you are longer than you thought?

MR. ORTVED: I am going to be optimistic.

THE COMMISSIONER: There is no such stance.

MR. ORTVED: I hope I am not in that position. If it comes to that I will have to --

THE COMMISSIONER: Sort out your life?

MR. ORTVED: Yes.

THE COMMISSIONER: All right. I think Mr. Tobias is asking, he has a problem which he thinks is urgent and he would like to dispose of it tomorrow so he doesn't want you to argue late tomorrow. He doesn't want you to argue after 4:30. Have you any objection to that?

MR. ORTVED: No. My suggestion would be that it be done later today.





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THE COMMISSIONER: He may not be  
ready. Are you ready to go on today?

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MR. TOBIAS: I will consult over  
the lunch hour and I will be able to tell you at  
2:15.

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THE COMMISSIONER: All right, that  
is fine. We will adjourn until 2:15.

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---Luncheon recess.

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1 ---On resuming at 2:15.

2 THE COMMISSIONER: Yes.

3 MR. TOBIAS: Mr. Commissioner, if I  
4 may - I am sorry, Mr. Scott, for interrupting - we  
5 are prepared, sir, to make our request whenever you  
6 find it convenient. That is any time today or tomorrow,  
7 we will leave the timing to you.

8 THE COMMISSIONER: I think it might  
9 be better in order for Mr. Ortved not to split, to  
10 argue it today. So we will argue it, and if Mr.  
11 Scott finishes - will you be finished by 4:30?

12 MR. SCOTT: No, I will be finished  
13 by the break tomorrow.

14 THE COMMISSIONER: You don't want to  
15 argue after 4:30 tonight anyway?

16 MR. SCOTT: No.

17 THE COMMISSIONER: Then we will excuse  
18 you and proceed --

19 MR. SCOTT: You can excuse me at four  
20 and that would allow my friend to --

21 THE COMMISSIONER: The only thing  
22 I worry about is that we may not get through with  
23 Mr. Ortved tomorrow. He says he is going to be half  
24 a day and you say you are going to be until the break  
25 and if you are excused at 4 then you will be half an  
hour after the break, or is this illogical?







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MR. SCOTT: I can be through, I am  
certain, by the break.

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THE COMMISSIONER: I could ask you to  
leave now and you would still be through by the break?

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MR. SCOTT: One way or the other.

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The advantage of duplicating that material is that I  
am not going to refer to most of it. I am going to  
tell you how it works and suggest how it may be used but  
I am not going to take you through that. I have just  
one or two more minutes and then I turn to the  
fascinating subject of the toxicological evidence and  
see if I can match Miss Cronk.

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THE COMMISSIONER: Can you give a  
thought to seeing what would happen if we went through  
without a break until about a quarter to 4 and then  
you will be relieved from there on until tomorrow  
morning.

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MR. SCOTT: That is fine.

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THE COMMISSIONER: Just think about  
that. If it looks as though it is not going to work at  
a quarter past 3 we will take our break at the  
regular time.

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MR. TOBIAS: Thank you, sir.

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MR. SCOTT: Now, Mr. Commissioner, I  
have been trying to deal with the non-toxicological

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2 factors and if you will just bear with me for a  
3 moment. Mr. Ortved I understand may be dealing with  
4 the subject matter of patterns and in any event you have  
5 my submission as to the limited use to be made of any  
6 alleged patterns that may appear in circumstances  
before you.

7 One of the basic problems, and I don't  
8 complain about this, I simply observe that it exists,  
9 in looking at what happened, is that the Commission  
10 and the experts who came before had the benefit of  
11 retrospective analysis. I am not complaining that the  
12 doctors in the Hospital did not. I am simply saying  
13 that there is inherent in retrospective analysis some  
14 difficulties that you have to consider. The deaths  
15 have therefore been examined not only in the context  
16 of the digoxin evidence but also in the context of 36,  
and in the case of some experts, more than 36 deaths.

17 For the clinicians the deaths had  
18 to be reviewed as they occurred within the context of  
19 a daily routine or as occurred here in the context  
20 of three conferences which were established to examine  
the deaths.

21 It is my respectful submission that  
22 even with a retrospective review of the exercise it  
23 cannot be said that the combined reviews were  
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inadequate so that you could formulate therein any conclusions about the nature of the deaths themselves. As Dr. Rowe testified in Volume 20 there were and there still are daily morning conferences, weekly pathology reviews, cardiac pathology conferences, and surgical pathology conferences. In addition to that there were ward rounds with ward chiefs, cardiac fellows, and paediatric residents and for the nursing staff, as Carol Brown testified in Volume 85, page 8556 there were nursing rounds in 4A and 4B every morning. Rounds were also held with the residents and fellows and there were cardiac rounds twice a week with the team leader or nurse in charge. Thus the flow of information through the staff of Wards 4A and 4B was facilitated and it was possible to examine the deaths of particular infants from a clinical point of view within the context, not remote but present, of their deceased state.

Now as the summer of 1980 progressed the staff of the Hospital was confronted by an increase in deaths on Wards 4A and 4B. This increase was not ignored. It was noted and it was troubling. The infants . however who succumbed presented no specific evidence to suggest that they died from anything other than their clinical course. With the possible eruptions of the







1  
2 babies, Woodward, <sup>Cook</sup> <sup>?</sup> and Velasquez each had  
3 considerable cardiac anomalies. They died with  
4 terminal events which in the absence of any other  
5 data could be conclusive of nothing more than that  
6 terminally ill infants were succumbing to their  
7 anomalies.

8 I am sure Mr. Ortved will review it,  
9 but a close examination of the deaths reveals nothing  
10 to allow the physicians to ascribe death to anything  
11 other than their clinical course until we come maybe  
12 to January or certainly March. Similarly the cluster  
13 of infants who died in December of 1980 had a profile  
14 which, while troubling because of its number, presented  
15 evidence only of extreme cardiac malformations. It  
16 was not really, and I think Mr. Lamek acknowledges  
17 this, until March 1981 that physicians and staff  
18 examining the babies from a clinician's point of view  
19 were presented with evidence of deaths brought about  
20 by external factors, that is to say, where there was  
21 evidence from which a diagnosis could be made of the  
22 presence of external factors.

23 THE COMMISSIONER: I am not at all  
24 sure it is any part of my mandate to take any position  
25 with regard to whether the doctors did or did not  
appreciate what was going on or should have appreciated





1  
2 it, but there is the case of David Taylor and I  
3 certainly somewhat surprised that they did not follow  
4 up that.

5 Was that not the one where in one of  
6 those conferences there was a suspicion of digoxin  
7 intoxication?

8 MR. SCOTT: Yes.

9 THE COMMISSIONER: And it was not  
10 followed up. There was a problem. Whether at that  
11 point they could still have found any toxicology that  
12 would have been helpful, I don't know, but nobody even  
13 worried about it or suggested it or considered it.

14 MR. SCOTT: I think if we now turn  
15 to my white volume, it may be that Mr. Ortved is  
16 going to address Taylor in some detail but Taylor is  
17 Tab 4, if you were lucky enough to get that, and I  
18 think if you look at the summary which we prepared I  
19 think perhaps the answer to it there is in the fourth  
20 paragraph Dr. Hastreiter noted that there was no  
21 evidence of aspiration at autopsy and that the child  
22 appeared to be improving. Therefore he concluded that  
23 the terminal episode was sudden and unexpected and  
24 that the probability of massive overdose was good.  
25 In testimony he stated that these children were prone  
to die suddenly but he felt that the clinical course





1  
2 indicated a good probability of digoxin overdose.

3 That is the case against retrospectively. At cross-  
4 examination he agreed with Dr. Rowe's analysis of  
5 the child but questioned the timing of the death.

6 As to whether or not the child was improving he  
7 stated that there were contra indications in the  
8 comments contained within the chart, and behind that  
9 you will have a note, I will not take you to it unless  
10 you want me to, sir, where the evidence on each of  
those experts on those points is found.

11 THE COMMISSIONER: What I have in  
12 mind I think is Miss Radojewski's notes of that meeting.  
13 Is that where we find the question of --

14 MR. SCOTT: Perhaps what I had better  
15 do is leave it to Mr. Ortved because I understand he  
16 is going to handle the reviews from that perspective.  
17 He tells me that is not only satisfactory, that it  
may be preferred.

18 Now one of the points Mr. Lamek made  
19 was to raise this question, what really happened on  
20 Wards 4A and 4B, and he referred for example at one  
21 stage to the theory that nothing really happened at  
22 all and suggested we agree that that would be a  
23 fairly naive view. But whether something happened is  
24 not itself an easy question to answer. I concede that  
25







1  
2 something happened. It is what that something was,  
3 even assuming it was one thing, that is more difficult  
4 to answer.

5 Now you have the CDC report and I  
6 must be frank to tell you that there were major  
7 questions raised in medical circles about the  
8 methodology applied in preparing the CDC report.  
9 As a result we considered it our duty to obtain an  
10 external review of that report, which we did and it  
11 was made by Dr. Haynes and his colleagues at McMaster  
12 University. It is Exhibit 328. That report confirms, one  
13 that there was certain methodological problems in the  
14 study of ward deaths as we suspected but the peers  
15 reviewing the report, secondly, acknowledged that certain  
16 parts of the study as designed were less than ideal.  
17 Given the circumstances in which they found themselves  
18 and the data sources they had they testified that there  
19 was a great deal of subjective decision making involved  
20 and you can see that by the reference to the classifications  
21 at the end of the report.

22 It was in that context, within those  
23 criticisms that the Hospital set to grapple with the  
24 problem, whether or not there was an increase in  
25 morbidity as reflected in the CDC report which  
was truly reflective of what happened on Wards 4A and  
4B.





BB.1

RD/ac

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2 Now, the Hospital is satisfied, as  
3 a result of Dr. Haynes' report, that there was  
4 a statistically significant occurrence -- that is  
5 the way it is put -- on wards 4A and 4B. That I  
6 am sure you will accept from the CDC report if not  
7 from Dr. Hayne's comments on, that there was a  
8 statistically significant occurrence, notwithstanding  
9 that there is dispute about methodology, but that,  
10 in itself, is not evidence of anything. Twist  
11 it and turn it, as we might, it tells you that there  
12 is a problem. It doesn't tell you anything about  
13 which, among the range of possible answers can be  
14 relied on.

15 Now, there were some other problems  
16 at the Hospital confronted in deciding how to help  
17 you in this inquiry. Concurrent with the calling  
18 of the Commission was an additional confounder,  
19 the Gary Murphy death, and the coroner's inquest,  
20 which found that this child had died from natural causes  
21 despite his high digoxin levels. When that  
22 determination was made, as you can imagine the  
23 scientists and the doctors were concerned about the  
24 impact of that on the statistical facts that were  
25 revealed in the epidemic period.

There was also, at the same time, the





BB-2

1  
2 issue of work on endogenous substances being  
3 performed by Dr. Seccombe and his colleagues. The  
4 results of the gutter blood study performed by  
5 Dr. Philips and Mr. Cimbura, clearly raised some  
6 problems for the Estrella post mortem reading. There  
7 were also and there remain grave concerns about  
8 digoxin levels reported in exhumed tissues and the  
9 possible interference of testing mechanisms.

10 Clearly there was the added confounder of  
11 the similarities between the symptoms of digoxin  
12 intoxication and the terminal events which might be  
13 expected from children dying of their own natural  
14 disease course.

15 Over the past year before you, sir,  
16 considerable evidence has been adduced from leading  
17 world experts on some of those matters. Many  
18 areas of concern have been alleviated. Others remain  
19 and remain less clear. This is not a reflection on  
20 the work of the Commission or of you, it is merely  
21 a reflection of the state of ongoing knowledge  
22 within the scientific community.

23 In her argument, Miss Cronk pointedly  
24 noted the fact that there is a great deal still to  
25 be learned about the nature of the drug, to which I  
will turn in a moment, although much has been learned







BB-3

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2 in the last three or four years. It is really  
3 because of these confounders and our efforts to  
4 deal with them, to explain them in a rational way,  
5 the efforts of all of us, and because of the  
6 potential for development in scientific knowledge  
7 that the Hospital urges you to take a cautious  
8 approach when examination the deaths under investigation.

9 In 1980 and 1981 there was a substantial  
10 lack of knowledge about digoxin and digoxin toxicity.  
11 We have advanced but we have still not advanced  
12 substantially beyond that stage.

13 To understand the position of the  
14 Hospital and I must be frank here, one must understand  
15 that there is a fundamental belief, albeit to  
16 cynical lawyers, perhaps, a naive belief, shared among  
17 medical people and scientific people, who give care  
18 to terminally ill infants that no one could intentionally  
19 mean harm to defenseless children.

20 As the Hospital for Sick Child frequently stands  
21 on the forefront of medical frontiers, with respect  
22 to the treatment of children, the medical staff  
23 naturally sees these confounders more frequently  
24 than they see consistency in the treatment of  
25 individuals. They recognize, as they must, as  
scientists, that every child is different and every





BB.4

1  
2 situation is different. There is little predictability  
3 in their treatment of children, therefore, in the  
4 absence of clear evidence it is natural and  
5 more consistent for them to conclude that some  
6 medical mystery was occurring on wards 4A and B then  
7 that someone had intentionally interfered with the  
8 medical course of these children.

9 That is not to say that you must or  
10 would want to harbour or labour under the same  
11 consideration, but it is to explain their view and  
12 it is to emphasize the importance in the scientific  
13 community of a cautious approach, because if answers  
14 are provided that in the end are not well-founded  
15 and are demonstrated to be wrong -- some may be  
16 demonstrated to be wrong through nobody's fault --  
17 by the application of unsound principles to the  
18 decision-making process, more harm than good will  
19 be done.

20 Now, Mr. Lamek urged you to generalize  
21 about the deaths of children who fall into what he  
22 called the uncertain category between natural death,  
23 on the one hand, and probable murder on the other.  
24 He has indicated that in light of the overall increase  
25 in deaths, the graph, you can conclude that those  
children about whom you are uncertain, were probably





BB.5

1  
2 the victims of intentional interference.

3 In my respectful submission, and I  
4 have said it before, but it is so fundamental, it  
5 is my respectful submission that you don't have  
6 the luxury, though you technically may have the  
7 capacity to generalize in that way, as labourious  
8 as it may seem, after 147 days of testimony, the  
9 duty owed is to deal with the cases uniquely and  
10 individually. Ironically, depending on the findings  
11 you make, the pattern alluded to by Mr. Lamek may  
12 or may not emerge. It may be modified and it may  
13 be different.

14 It is our submission that today,  
15 more than three years after these events, we possess  
16 in certain cases, hard evidence of digoxin involvement  
17 in a certain number of cases. Only where that  
18 data is available can you attribute the child's death  
19 to that source.

20 We submit that what is required is  
21 a review of the testimony as it relates to each  
22 baby. It would be <sup>un</sup>scientific and illogical to  
23 attach a high degree of suspicion and foul play to  
24 deaths, because of their numbers alone. Even with  
25 the benefit of hindsight and the toxicological data  
the index of suspicion reveals that although the deaths







BB.6

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2 were high in number the vast majority of them  
3 can be attributed to circumstances which today  
4 bear low suspicion, low scientific suspicion or  
5 relate to natural causes.

6 When there is sufficient evidence,  
7 you must, of course, find the cause of death. When  
8 the evidence is lacking or is of the type of  
9 circumstantial evidence to which I have directed  
10 myself this morning, you must, in our submission,  
11 conclude that these children died in a manner which  
12 was consistent with their clinical condition.

13 Now, I am obliged to turn to -- this  
14 may be the case of a blind man, but I am obliged  
15 to turn to the evidence about digoxin. We have  
16 now dealt, as best I can, with the impact, as I see  
17 it, of the non-toxicological factors that Mr. Lamek  
18 advances before you. I say almost none of them  
19 are going to provide any significant assistance  
20 in resolving the problem that you have in light of  
21 the clinician's testimony.

22 There is hard evidence in a few cases  
23 of digoxin and it is important to turn to that, to  
24 see what we know about digoxin and what use you  
25 can make to what extent is the toxicological  
evidence hard and, therefore, useful for a fair





BB.7

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determination of the cases.

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Now, I purpose to deal with this subject basically under the general headings that Miss Cronk advanced in her argument, as a matter of convenience, and you will find that there is a substantial measure of agreement between the Hospital and Miss Cronk on the submissions that she has made but there are some important differences.

First of all, when she was dealing with function and effect of the drug, Miss Cronk emphasized, I think properly, that despite the scientific advances of the past three years, much remains to be learned about the drug. That is made clear with, if one refers to the conclusions of the digoxin conference, which was held in November of 1983. That conference, as you will recall, arose and was convened as a direct result of the confounding determination of the jury in the Gary Murphy inquest, which suggested that there could be high levels of digoxin, indeed quite high levels of digoxin, and a natural death.

The Hospital convened the conference, to which it invited world renowned experts for a sort of a think-tank session. I think Mr. Lamek in the end even got to go.





BB.8

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THE COMMISSIONER: Whatever happened to the minutes of that? Weren't we supposed to get them?

MR. SCOTT: We can get you a copy if you want them.

THE COMMISSIONER: I don't think it is going to tell us much because I think the evidence was that there were more questions than answers, but I would like to have it.

MR. SCOTT: The data is to be published and if you would like to have it before it is published I don't see any reason why that shouldn't be done.

THE COMMISSIONER: If it is published after my report it won't be a lot of use. Perhaps I should get it before.

MR. SCOTT: I think what you will find, I think you have correctly assessed the point that it makes. The purpose of the conference was to establish a foundation for future research into digoxin by determining exactly what was known and what was unknown as at November 1983 and really the most significant conclusion that was drawn, and I will try to get you a copy of it, is that extensive research is still required before it can be said







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with any assurance that we understand the pharmacology of the drug, though headway has been made. The significance of the conclusion lies, not only in itself, but in its source. I mean this was not simply a group of scientists reviewing basic pharmacology; it was the world's experts on the drug, each selected for a specific expertise associated with digoxin.

Dr. Bain referred to the general conclusions of the conference in Volume 61, page 3563 and following. Now, your difficulty if I may put it this way, among others is that you are going to have to make some determinations, or you are being asked to make some determinations, on the basis of knowledge which is in a state of very uncertain flux.

Now, it may very well be, as I think Mr. Lamek may have said to the press at one stage, that we know more about digoxin than anybody else and it may very well be because we have devoted a lot of time to it over the last year but --

THE COMMISSIONER: I hope he was speaking for himself.

MR. SCOTT: And he may know more than anybody else, but the point is that nobody really





BB.10

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2 knows very much and, therefore, when you look at  
3 the pharmacological evidence you are going to  
4 have to be very careful in a way you wouldn't be  
5 if you were dealing with some other substance,  
6 to be certain that you are dealing with a conclusion  
7 that is accepted, rather than a mere speculative  
8 opinion.

9 Now, I said to you earlier, as one  
10 of my standards, that you should be very reluctant to  
11 reach a conclusion, indeed should not do so on  
12 a medical matter unless there is a fair consensus  
13 of medical doctors in support of the proposition, that  
14 where there is an eminent expert weighing in on  
15 the other side you should not regard the matter as  
16 concluded.

17 We discussed that yesterday and there  
18 are views about that and I'll leave that aside.  
19 Whether that principle is true generally, with  
20 respect to clinical examination, it has got to be  
21 true in spades, in terms of the operation and  
22 measurement of the drug, digoxin, because when you  
23 say and it is undoubtedly that it is the business  
24 of the Court or a judge to assess two experts and  
25 accept the opinion of one over the other, as you  
would in a normal case, it becomes increasingly





BB.11

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difficult to do when both of them are speaking  
at the fringe, if not beyond the general fringe  
of accepted scientific understanding.

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With the greatest respect for all  
the experts who did their best to help us all,  
there are places at which, unless a clear concensus  
of knowledge is achieved, it would be difficult  
and dangerous to rely on evidence.

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CC/DM/ko

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2 Now we know some things, for example. We know  
3 something of the significance of the alpha phase of  
4 distribution, and the significance of the beta phase  
5 of distribution, we have all had a little course on  
6 that. It should be emphasized, and I am sure this is  
7 understood, with respect to the alpha phase, with the  
8 half life of approximately 30 minutes that digoxin  
9 levels would be extremely high in the blood or serum  
10 immediately after the administration of the drug before  
11 it distributes. It should indeed be emphasized that  
12 any blood samples drawn during this time period, as  
13 has been said, could well produce artificially  
elevated digoxin readings.

14 Reference was made to only one child,  
15 the Baby McKeil, in whom it was believed that digoxin  
16 sampling had occurred prior to distribution in the  
alpha phase.

17 Ther is a critical point that arises.  
18 For those children in whom we do not know the time of  
19 the last administration, or the time of the last  
20 sampling of blood, it may well be that samples were  
21 drawn too soon after the time of administration of the  
22 drug, thereby resulting in artificially elevated serum  
digoxin levels.

23 THE COMMISSIONER: We do generally  
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CC 2

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speaking know the time of the --

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MR. SCOTT: Administration?

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THE COMMISSIONER: Well the time of the administration, the last official administration, the last authorized administration, and we do know the time of the taking of the blood.

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MR. SCOTT: Yes. All I am saying is you have to be certain that those are accurate.

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THE COMMISSIONER: Well I can't be certain they are accurate because one of the theories of course is the last administration was not an authorized one.

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MR. SCOTT: Leaving aside the unauthorized administration.

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THE COMMISSIONER: I don't believe that there was any suggestion that any of these readings were taken too soon, any of the ones we are talking about, the ones, the serum readings --

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MR. SCOTT: That may be but that is a caution that you have to consider.

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THE COMMISSIONER: That's right. There really are only four, Cook, Miller, I am sorry, five, Cook, Miller, Inwood, Pacsai and Estrella are the only five, and there is no suggestion in any of those that the sample had been taken too soon, is there?





CC 3

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2 MR. SCOTT: There is no evidence that  
3 the sample was taken within the time frame I am  
4 talking about. What I am saying is that having heard  
5 this for months, we are beginning to assume there is  
6 something in - that the process is mechanically known  
7 and as long as you take it here you are going to get  
8 an accurate reading, and if you take it there you may  
9 not get an accurate reading. It is not in my  
10 respectful submission as clear as that. There is no  
11 certitude about the length of the alpha phase. There  
12 are good estimates that vary about the length of the  
13 alpha phase, it is something that we have begun to  
14 study, but it is a caution that you have to have. We  
15 know that there is an alpha phase because that is what  
16 we call the distributor phase. We are not yet at the  
17 stage of scientific certainty about its length or  
18 effect. We do know that if you take your measurement  
19 in that phase, however long it may be, you may have a  
20 problem. Therefore, when a scientist says to you that  
21 the life of the alpha - that the alpha phase is  
22 approximately 30 minutes.

23 THE COMMISSIONER: The half life.

24 MR. SCOTT: The half life.

25 THE COMMISSIONER: The life would be  
two and a half hours.







CC 4

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MR. SCOTT: Yes, but he is not talking about something that is known with certainty like the fact that June is 30 days. He is giving an opinion based on the state of scientific knowledge about that time frame and there is there room for error, it is not a mechanical consideration that you can simply take and apply.

With regard to the beta phase with the half life of 20 to 80 hours, and total time for excretion ranging from 5 to 20 days, you will want to consider that evidence in relation to the detection of digoxin in Babies Belanger and Lombardo.

With regard to Lombardo, I draw to your attention Dr. MacLeod's suggestion, in Volume 64 at page 4279, where he suggests that one could detect digoxin using GCMS techniques from a dosage administered at any time during 10 days preceding the death of the child. What bearing has that? That has bearing on the extent to which you can judge not whether the child had digested digoxin but rather the extent to which you can conclude from that that the administration was an example of foul play.

Dr. MacLeod's opinion appears logical in light of the beta half life of between 5 and 20 days. In the same way Dr. MacLeod makes the same





CC 5

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Hachiler:  
concentrations  
> therapeutic  
in serum  
digoxin dose  
not produced

suggestion about Baby Belanger --

THE COMMISSIONER: Five to 20 days or  
5 to 20 hours?

MR. SCOTT: Days.

THE COMMISSIONER: Days, thank you.

MR. SCOTT: Dr. MacLeod makes the same  
suggestion for Baby Belanger using a time frame of 35  
days. On the basis of Dr. MacLeod's evidence one could  
then explain the presence of digoxin in two babies who  
were not prescribed the drug on the basis of a single  
medication error occurring some time during the  
child's life of either 10 or 35 days. Now I don't say  
that is the explanation you may accept. I say that  
on the fringe of science that view has to be seriously  
considered, not for the purposes of accepting and  
rejecting it. You or I, with the greatest of respect,  
could not accept it or reject it, but because it may  
impose an important qualification on the extent to  
which you can determine whether the drug was  
administered deliberately for the purposes of causing  
death. I assume, for example, that digoxin administered  
in quantities even sufficient to be left over the  
period which did not produce a death except 35 days  
later, would not necessarily be found by you to be a  
drug administered with foul play as the purpose. The





CC 6

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2 longer the period the closer you may come to deciding  
3 that was an accidental administration.

4 So those are factors, they are not  
5 matters that can be applied as a rote, there are no  
6 rules, you can simply have at this stage the competing  
7 opinions of experts each entitled to consideration  
8 about what the pharmacokinetics of the process are.  
9 In my respectful submission when you observed, sir,  
10 this morning that as a trial judge you could and would  
11 have to either accept or reject the evidence of some  
12 consultant in an ordinary civil case, who gave evidence  
13 on some mining technique or what have you, that is one  
14 thing. In my respectful submission you can't approach  
15 this technical evidence in that way. You can't say at  
16 this fringe that I reject Dr. MacLeod and accept  
17 Dr. Kauffman or whoever, both are expressing opinions  
18 and the best you can do is say there is a bundle of  
19 knowledge which ranges from this point to that point,  
20 I can apply it as a range of information to the  
21 problems of our case, and it will either point to a  
22 solution of them, or I will have to say on the medical  
23 knowledge, scientific knowledge, I cannot.

24 Now the problem is real. Because on  
25 the other hand you have against Dr. MacLeod's evidence,  
Dr. Kauffman's evidence at Volume 71, pages 5600 and







CC 7

1  
2 following. He disagrees with Dr. MacLeod, suggesting  
3 that digoxin would have been completely excreted even  
4 prior to the 10 day time frame.

5 Now there you have a fundamental  
6 difference of opinion between scientists which may be  
7 critical when you come to conclude not whether the  
8 Baby Belanger had digoxin in its system, but whether  
9 the administration was deliberate. In my respectful  
10 submission you can simply note the divergencè of  
11 scientists on this important and critical issue, and  
12 if you can make something of the range of their  
13 opinion you can do so, but to say at this stage of  
14 knowledge that I accept Dr. MacLeod's opinion over  
15 Dr. Kauffman's is probably going to win you the Nobel  
16 Prize for some scientific discovery, but it is not, in  
17 my respectful view, an approach to the problems of  
18 this type that is warranted at this stage of our  
19 knowledge.

20 THE COMMISSIONER: Well, we are faced  
21 with that, and I come back I suppose to what we were  
22 discussing yesterday, that is the nature of the  
23 mandate. I am told - I know you say I am entitled to  
24 say and I am sure I am entitled to say I just can't  
25 determine this question because there is a difference  
of opinion as far as the experts, and although digoxin





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CC 8

has been around for 250 years nobody bothered to find out anything about it until the last 15 minutes, and therefore I am not going to make a decision. There is a rather modern and very popular vernacular for that sort of action, people have described it and in these political days --

MR. SCOTT: Let me put it to you. It is a critical feature about what you do and it must be grappled with and I am not reluctant to - I am delighted that you are concerned about it and I am anxious to help.

The problem is that in a civil trial, or in a criminal trial where you have to have adversaries, the problem has to be resolved and the consensus of the community is that any resolution at a certain point is better than no resolution. That is why you are entirely right, sir, when you say that a trial judge is by training and by direction of the Superior Courts told that he must decide it, we will look after it if you decide it wrong, but you must decide, this knot must be cut.

What you have here, and the importance of this is, you have a state, you have a problem and you have a state of great concern that runs all the way from those whose concern is reasonably unsophisticated





CC 9

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2 like my own, to the concern expressed by people who  
3 authored the CDC report. None of them can solve the  
4 problem, none of them. So they say, well we will  
5 appoint a Royal Commission. Now your function is to  
6 tell them to what extent you believe the problem to  
7 have been solved. It is not to solve it for them, you  
8 couldn't possibly do that. If you do, if you attempt  
9 to do what cannot be done in those areas where the  
10 evidence fails you, it will rob those other parts of  
11 your report which are accurate of the required  
12 assurance. For example, if there is strong evidence  
13 that that baby was killed, the parents are entitled to  
14 know that, even if it means, and especially if it  
15 means that we cannot give the same assurance one way  
16 or the other to another set of parents. To try to  
17 assure everybody of an answer, to let everybody leave  
18 with an envelope with an answer in it, would be to  
19 discount that part of the report where the assurance  
20 exists.

19 THE COMMISSIONER: You think that the  
20 parents, the hospital and everybody else would be  
21 happier if - assuming I am in doubt but still believe  
22 one way or the other it would be better not to say, is  
23 that what you think, for the sake of the parents, for  
24 the sake of the hospital, for the sake of the public?  
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CC 10

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MR. SCOTT: No, for those two reasons, but also for the sake of the validity of your report.

THE COMMISSIONER: But if I express it that way, if I have reasonably firm convictions one way or the other on Baby A or Baby X?

MR. SCOTT: Yes.

THE COMMISSIONER: Baby J I am far from certain, but I lean one way; and Baby K I am not certain but I lean the other way. Is there something wrong with that?

MR. SCOTT: Tell us about Babies A and B.

THE COMMISSIONER: A and X.

MR. SCOTT: A and X, I am sorry, A and X, and you would tell us why?

THE COMMISSIONER: Yes.

MR. SCOTT: And I am entirely confident, as I am sure all of us are, that if you are confident about Babies A and X, we have probably come as close to the right result, there is nothing infallible about any of it, but we have come as close to the right result on Babies A and X as we are likely in a human experience to get.

THE COMMISSIONER: Okay. If I say I can't tell you about Babies J and K.





CC 11

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MR. SCOTT: If you say I am telling  
you about Babies A and X; I have my suspicions about  
B and K; and your suspicions about B and K subsequently  
turn out, as sometimes develops, to be totally  
unfounded and unwarranted, that damages your report  
with respect to Babies A and X.

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DD-1

DP/ac

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What we want to see, I speak only  
for the Hospital, the reason we are here is because  
we want what assurances we can get. Now you may  
say why should I not have been put up here with  
a bunch of scientists and maybe that might have been  
a help but you were not and you are just going to  
have to soldier through, you are going to have  
to do it as you can, but the prudent course it seems  
to me is to say what you can know with that level  
of assurance. Then if somebody says, well you did  
not tell us anything about the following 15 babies,  
your answer is, we don't know enough about the following  
15 babies and what do you want, some more gossip?  
We don't know enough and I can't tell you and it  
may be in 10 years we will know, but we don't know  
now. The advantage of that is that then what is  
certain is removed from the area of speculation and  
what is uncertain is left where it should be in  
the area of speculation.

I must say from the beginning I  
assumed that that would be the function of the  
Commission. I must say I gave no real consideration  
to the possibility that we were going to sort of  
take the Commissioner's pulse on each of these babies.  
We were going to invite him to evaluate where the







DD-2

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2 hard knowledge was, if any, and tell us and let  
3 us at least put to rest the spectre in those  
4 areas where we can. It may be that it will be  
5 five years or ten years or never as Mr. Lamek says  
6 that we can put the spectre to rest in other  
7 areas.

8 Now Miss Cronk next turned to the  
9 reliability of analytical techniques and dealt with  
10 the state of the art, as I think she called it, in  
11 1981. We do not take any issue with the description  
12 of the analytical techniques which she gave, but it  
13 is apparent from the evidence and this is a factor  
14 to be borne in mind in what weight you give to the  
15 evidence that Dr. Ellis and Mr. Cimbura, the  
16 Hospital for Sick Children and the Centre of Forensic  
17 Sciences or indeed anyone else had any experience  
18 of significance with digoxin analysis in the spring  
19 of 1981. Mr. Cimbura, as you will recall, said that  
20 in order to do the job that he was asked to do he  
21 had to develop for the first time certain tests to  
22 analyze various samples. Dr. Ellis indicated that  
23 RIA as a detection technique for digoxin and other  
24 drugs had only been in the Hospital for a few years,  
25 I think since 1975, and until March of 1981 its  
application in the Hospital was limited to determining





DD-3

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serum levels of living patients. No post mortem  
levels were done as there was no need to do them.

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THE COMMISSIONER: One was done -

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Estrella.

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MR. SCOTT: That is right. There was  
in addition no screening, equally important, perhaps,  
of patients who had not been prescribed the drug  
for the drug. The purpose of the serum levels was  
strictly to assist the clinicians in evaluating  
the progress of their cardiac patients.

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You referred to Estrella and we  
talked about an artifact occurring in the Estrella  
case and we will come later to whether there was  
an artifact or not or whether that could be relied  
on, but I think that simply illustrates the novelty  
of the entire exercise for all practical purposes.

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It was true for Dr. Ellis as well as for Mr. Cimbura.  
As a result when the evidence is clear you act on  
it but when the evidence is murky, on the fringes,  
you take account of the novelty of the exercise in  
which everybody was forced to engage. Indeed

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Mr. Ellis told you that as of 1981 that such information  
did not come into the lab such as the time of  
administration of the drug, the time of sampling and  
the prescribed dose as it was not at the time felt,





DD-4

1  
2 this was 1981, to be of significance. That was the  
3 state of the art in 1981. People did not understand  
4 even then the impact that those factors had on  
5 the reading that was produced. These are simply  
6 examples of the extent to which our knowledge  
7 of digoxin has progressed over the past three years.  
8 Now things that we would accept as mandatory as  
9 a result of experience can be established in 1981,  
10 when many of the readings with which you are  
concerned were taken. These were virtual unknowns.

11 Indeed Dr. Ellis says that in 1980/1981  
12 no one was aware of any naturally occurring substance  
13 like Substance X which could contribute to the  
14 digoxin levels. Now, I don't say that that means  
15 that Substance X is going to answer everything, that  
16 it is all Substance X and there is no digoxin. I  
17 simply say isn't it remarkable that three years  
18 ago something that is now generally accepted was  
19 completely unknown. Where will we be three years  
20 hence? You and I may be here but assuming we are  
21 not, you won't have to answer that question, but  
22 it is a caution on the use you make where there  
is scientific dispute of the evidence given by one  
participant or another.

23 In summary, as of March 1981, the Hospital's  
24  
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DD-5

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2 experience with digoxin testing was limited,  
3 largely to the determination of anti mortem serum  
4 digoxin levels solely for the purpose of assisting  
5 the clinicians with their treatment of their  
6 patients. Up until that point in the clinical  
7 oriented environment of the Hospital there had been  
8 no reason to establish any ante~~e~~ mortem screening  
9 program or any methodology for post mortem serum  
10 levels or any tests for digoxin tissue levels either  
11 ante~~e~~ mortem or post mortem and there is no evidence  
12 that the approach of this Hospital was any different  
13 than any other Hospital of comparable size, experience  
14 or background.

15 Mr. Cimbura's evidence indicates  
16 a similarly limited exposure to methodologies on  
17 the part of the Centre as of March 1981. Although  
18 he was generally familiar with RIA he had had no  
19 personal experience with RIA as a digoxin test nor  
20 had anybody else in the Centre. Although they had  
21 the equipment they had to develop the protocol,  
22 none was available, as there had been no demand for  
23 this type of analysis.

24 With regard to the literature available  
25 at that time, Mr. Cimbura indicated that most RIA  
literature dealt with pre-mortem serum analysis.





DD-6

1  
2 There was little if any literature that dealt with  
3 RIA analysis of digoxin and tissue samples. As a  
4 result he had to develop and did develop his own  
5 techniques and therefore with regard to tissue  
6 samples one can easily understand Mr. Cimbura's  
7 hesitancy when he was requested by the police to  
8 perform analysis on tissues. Indeed I think he told  
9 us he did not respond the first time they asked him,  
10 they had to ask him twice before he agreed to even  
11 attempt the project. His reservations are fully  
12 appreciated for at least three reasons: first of  
13 all, inexperience of himself and his staff; secondly,  
14 the absence of literature; and thirdly, the fact  
15 that the police, as he notes in Volume 3, page 205,  
16 were requesting tests not on one kind of tissue but  
17 on a variety of tissues. The analysis of the tissues  
18 required the introduction of additional extraction  
19 and recovery steps to prepare the tissue in a form  
20 which could be utilized. Each additional step, then  
21 extraction and recovery, added further variations  
22 to the final outcome of the analysis. although  
23 at that stage of the development of the technique  
24 it was not felt that a correcting factor was necessary  
25 to account for lost recovery.

To Mr. Cimbura's credit he indicates that





DD-7

1  
2 once the HPLC had been sufficiently refined all  
3 the tissues that reported in sufficient quantity  
4 were re-analyzed using a combination of RIA and  
5 HPLC.

6 Now it is important for the Commission  
7 to note that Mr. Cimbura had an even more difficult  
8 task to perform than did the Hospital. For the  
9 analysis of the blood and serum samples it was  
10 necessary that he should refine the RIA protocol  
11 to ensure its specificity for digoxin while at  
12 the same time develop an HPLC protocol which would  
13 separate some digoxin-like substance from the actual  
14 digoxin. He was also charged with the additional  
15 responsibility of developing appropriate purification  
16 techniques to allow for the analysis of digoxin  
17 levels in various forms of tissue, something which  
18 had not previously been attempted at least anywhere  
19 in Canada. In the light of the obvious time  
20 constraints imposed in March 1981 and the fact that  
21 much of the methodology had been developed it is  
22 a credit to Mr. Cimbura and his staff that the  
23 scientific experts attending the March 19th seminar  
24 at the Hospital generally accepted his digoxin data  
25 in the context of the four babies in which it  
was presented.







DD-8

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3 One must recognize that as of  
4 March 1981 both the Hospital and the Centre were  
5 utilizing therefore methodology which were all that  
6 were available at the time and which may be said to  
7 be relatively rudimentary. The conference of  
8 March 19th, 1984 was convened, and you will recall  
9 that, that is the conference which was arranged by  
10 Mr. Cimbura, the Attorney-General's Department and  
11 the Hospital and it was for the specific purpose  
12 of considering the digoxin data arising from two  
13 sources. With regard to only four of the babies  
14 under consideration, Lombardo, Belanger, Cook and  
15 Hines two points emerge from the report of the  
16 panel - I will get you the Exhibit number - Exhibit 399  
17 at paragraph 6(3) of the Summary of Recommendations  
18 the panel says:

16 " It was felt that the current state  
17 of the art was such that no assurance  
18 could be made that the further use  
19 of GCMS would provide in the near  
20 future an unequivocal answer to  
21 the question of whether or not  
22 digoxin is present in the tissues  
23 available for examination. "

24 In our respectful submission, it is clear  
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DD-9

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from that statement that despite the increased sophistication of the technology we have yet to refine a technique that will offer a resolution of the presence or absence of digoxin in tissue samples.

7

In my respectful submission --

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THE COMMISSIONER: I thought that was related to the GCMS.

9

MR. SCOTT: Yes, it is.

10

THE COMMISSIONER: Look at 5(2) on the page before.

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MR. SCOTT: Yes.

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THE COMMISSIONER: Perhaps I did not study this sufficiently but I understood that the panel was generally speaking satisfied that the RIA and HPLC method did produce an assurance of the presence of digoxin. What they are saying in 6(3) is the development of GCMS or the GCMS method has not reached the state where it would help us particularly. I thought that they were generally speaking satisfied with the HPLC and RIA methods. Do I misread it?

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MR. SCOTT: Maybe I better take five minutes and be sure.

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THE COMMISSIONER: Maybe we better take





DD-10

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20 minutes and have our break. I think that is  
a sensible thing to do and then whenever you want  
to quit after that I will go right ahead into the  
motion.

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MR. TOBIAS: Thank you, sir.

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--- Short Recess.

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RD/cr

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2 ---On resuming at 3:45 p.m.

3 MR. SCOTT: Mr. Commissioner, there  
4 are just two cautions that I want to put before you;  
5 one in respect of RIA and one in respect of  
6 endogenous substances. These are advanced as modest  
7 qualifiers or antidotes to the broad statement made  
8 by assistant Commission Counsel in discussing with  
9 you or in reading to me, which is all I can get out  
10 of it, the general conclusions that she drew from the  
11 evidence. They are these, and first of all with  
12 respect to the technique. The conference of March  
13 19, 1984 was convened to examine the samples from the  
14 four babies noted, Lombardo, Belanger, Cook and Hines  
15 and taking the paper out of its order, the panel  
16 concluded that in paragraph 6(3), that in the current  
17 state of the art there was no assurance that the  
18 future use of GCMS would provide an unequivocal  
19 answer. It was hoped at one time that it might be  
20 able to provide, in short order, an unequivocal  
21 answer to the problems that were presented. The panel  
22 reported in a sense negatively on that.

23 The panel also examined and heard from  
24 Mr. Cimbura a description of the way in which the  
25 samples were prepared for RIA/HPLC examination in  
those four cases.





1  
2 It is my belief that he gave them a  
3 full and detailed and thorough and apparently an  
4 entirely satisfactory account of what he did in  
5 respect of those four samples.

6 In paragraph 5(4) the panel concluded --

7 THE COMMISSIONER: 5(4) or 5(2)?

8 MR. SCOTT: I'm sorry, 5(2).

9 In the context of the cases under  
10 discussion the panel placed a much higher degree of  
11 reliance on HPLC/RIA than on GCMS data.

12 Now, the caution to which I refer is  
13 the recognition that this panel passed on the cases  
14 under discussion, and with respect to the cases under  
15 discussion, I accept what has been said in that  
16 report, but nothing else was passed on by the convened  
17 conference. That, respectfully, insofar as other  
18 samples are concerned, is a matter that you should  
19 note. I put it no higher than that.

20 So that other samples we do not even  
21 have the assessment of the conference with respect  
22 to the degree of accuracy that we may anticipate.

23 Now, with respect to her submissions  
24 made on the subject of Substance X, assistant  
25 Commission Counsel concluded that the maximum reported  
level of Substance X is approximately 4 nanograms,  
based on the work of Dr. Seccombe in Vancouver and that,

*Chinty!*





1  
2 of course, is entirely accurate and no one quarrels  
3 with that state of his conclusion. What we do know  
4 is that there is, nonetheless, a Substance X and if  
5 I understood assistant Commission Counsel correctly  
6 she concluded that Mr. Cimbura, when employing the  
7 separation technique of HPLC was, in fact, separating  
8 out pure digoxin in the absence of any Substance X.  
9 She said it is only 4 nanograms and not to worry, but  
10 even if 4 nanograms might make a difference, Mr. Cimbura  
11 can separate it out.

12 In my respectful submission the evidence  
13 does not go that far and it is a matter that you  
14 should cautiously consider when weighing the effect  
15 that is to be given.

16 THE COMMISSIONER: Is it not a fact  
17 that Dr. Seccombe did not use the HPLC method?  
18 That is one fact and the second fact is that Cimbura's  
19 tests did not produce the results that he did, because  
20 Cimbura's tests, which were RIA -- if I knew what  
21 I was talking about I wouldn't have so much trouble  
22 with this -- HPLC.

23 MR. SCOTT: You think you are having  
24 problems.

25 THE COMMISSIONER: I think those were  
the two things he did say. He said, first of all, that







4  
1 he did not have the results that Seccombe had in his  
2 experiments, but he also said that he was using RIA/  
3 HPLC. Am I right or wrong?  
4

5 MS. CRONK: That is correct, sir.

6 MR. SCOTT: I understood the first  
7 point to be that no one has produced any more than  
8 Dr. Seccombe and he only gets 4 nanograms.

9 THE COMMISSIONER: That is right.

10 MR. SCOTT: So it is a problem of a  
11 modest dimension, that is the theory, and not to trouble  
12 us when we are dealing with these big figures.

13 The second thing I understand that he  
14 said is that the Cimbura technique can separate out  
15 any endogenous substance, if such there be, so even if  
16 it was 40 nanograms you don't have to worry about it,  
17 because this technique will separate it out.

18 In my respectful submission we are  
19 at the preliminary stage and it is a matter of caution  
20 that the evidence does not go that far. What Mr.  
21 Cimbura said is that he believes that Substance X  
22 does not exit the column at the same time as digoxin.  
23 The problem that was presented and remains unresolved  
24 is that that may not be so if Substance X is identical  
25 or virtually identical in structure to digoxin.

THE COMMISSIONER: It wouldn't be so,





1  
2 but the fact of the matter is that Cimbura, using  
3 his tests, didn't get the results that Dr. Seccombe  
4 got in Vancouver. They used different antibodies and  
5 did all sorts of things, but his system was different  
6 in that he did not get that result and it is possible  
7 if one were to conclude that had Seccombe done the  
8 same thing he wouldn't even have got his 4.1, he would  
have got nothing.

9 MR. SCOTT: Then you have the problem  
10 of dealing with Exhibit 247, the La Bella article,  
11 is there an endogenous digitalis, because there the  
12 research is concluded and I quote that "the active  
13 material"-- they didn't call it Substance X, they  
14 called it the active material, which we refer to as  
15 Substance X -- "was present in an HPLC fraction that  
cross-reacted with antiserums of digoxin."

16 All I am saying is that to make the  
17 point that the assumption that we are at a stage of  
18 highly developed expertise and knowledge, with respect  
19 to digoxin, let alone Substance X, is not shown.  
20 We are at the preliminary stage, much advanced over  
21 the state of the art in 1981, but still very much at a  
22 preliminary stage and while you can, on the basis of  
23 the panel's review, rely confidently on the readings  
24 that were considered by, which were the cases under  
25





1  
2 discussion in the panel, and while you can take  
3 account of the fact that the maximum Substance X  
4 is 4 nanograms, you will be cautious in representing  
5 that this is anything like a complete understanding of  
6 the subject and that a completer understanding, which  
7 we will come to in the fullness of time, may alter the  
8 knowledge that we see now prepared in some cases to  
act on.

9 The point I am going to make to you  
10 tomorrow morning is that even when you come to the  
11 toxicological data there is a mandate to take a  
12 cautious approach in selecting the toxicological  
13 data on which you rely, leaving aside that data which  
14 has any unreliable features. It is in that context  
that I put these considerations to you.

15 Now it is almost 4 o'clock and I  
16 am not ill like Mr. Lamek, but I am tired and I  
17 would appreciate it if we could stop.

18 THE COMMISSIONER: Certainly, that is  
19 fine. Thank you, Mr. Scott.

20 We will now proceed if you are ready  
21 to go. For the benefit of other counsel it is an  
22 application to have me state a case with respect to the  
23 parents' representation of Phase II. Those who are  
24 interested will remain and there is no reason why  
25







1  
2 you can't remain even if you aren't interested.  
3 Obviously Mr. Scott is not interested.

4 MR. SCOTT: No, I want to speak to  
5 Mr. Ortved. I am fascinated and we will hear it on the  
6 sets.

7 THE COMMISSIONER: All right.

8 MR. TOBIAS: Mr. Commissioner, this  
9 is an application that I make on behalf of my own clients  
10 the Hines family, an application that I will be joined  
11 in by all of the counsel for other parents. They will  
12 have submissions to make to us, as well, directly on  
13 point.

14 As you have quite correctly stated,  
15 it is a request at this point to ask you to state  
16 a case to the Provisional Court concerning your  
17 judgment of yesterday. As I read the judgment, and  
18 as I understood its effect, you have, upon your  
19 reading of Section 5(1) of the Public Inquiries Act  
20 denied the parents' application for standing on a  
21 number of bases, including that you were not satisfied  
22 that they had demonstrated a sufficiently direct and  
23 substantial interest in the subject matter of what  
24 you have come to refer to as Phase II of this process  
25 and, as well, that they have failed to satisfy you  
that if there is a substantial and direct interest





1  
2 that it would in any event be any different from the  
3 interests of the public in general, and you make the  
4 point in your judgment, as I read it, that Commission  
5 Counsel is here to protect the interests of the  
6 general public.

7 THE COMMISSIONER: The second part.  
8 I certainly did not have in my view a legal sense,  
9 a substantial and direct interest on the subject matter.  
10 In my view they have more direct and substantial  
11 interest than the public who is represented by  
12 Commission Counsel.

13 MR. TOBIAS: I stand corrected. I  
14 think, though, no matter how it is viewed, which you  
15 seem to be saying in the first instance you are not  
16 satisfied of a substantial and direct interest, in  
17 any event, and if there is it would not be any different  
18 than the public interest. That doesn't mean to say  
19 that you accept, and I don't mean to imply that you  
20 do accept that the public generally has a substantial  
21 and direct interest. It seems to me, in any event,  
22 those are the two central questions that we are looking  
23 at.

24 With the greatest of respect to you,  
25 the request is simply made, because after a careful  
reading of your judgment and after consulting with my





1  
2 clients, it is my submission that you erred in making  
3 that ruling and coming to those conclusions.

4 It would also be my submission that  
5 the test of substantial and direct interest respect-  
6 fully has been met and that we did make out a case for  
7 it and that with great respect you erred in holding  
8 that it had not been met.

9 As well, I would point out that if  
10 I am right, and I don't intend to argue that today,  
11 because that is arguing on merits and that is why I  
12 am asking to take it to another forum, but if I am  
13 right then clearly on my reading of Section 5(1) of  
14 the Public Inquiries Act, if we have made out that  
15 interest the question of standing does not become  
16 a discretionary matter.

17 THE COMMISSIONER: No.

18 MR. TOBIAS: The word "shall" is  
19 used and clearly the central question is a mixed  
20 question, if you like, of fact and law in interpreting  
21 the words direct and substantial and whether or not  
22 we need that test.

23 With respect to the question put  
24 before you today of whether or not there is sufficient  
25 merit in the submissions to justify the stating of  
the case I would like to direct myself to three points.







1  
2 In the first case I think one of the things that  
3 you, with great respect, must look at in an  
4 application of this sort, is the importance, the  
5 practical importance and the legal importance of the  
6 question itself.

7 I submit to you on that basis that  
8 no question that can be brought before you could be  
9 of more central importance than this particular  
10 question for this reason: What we are concerned with  
11 here is not how the proceedings and how the Inquiry  
12 will be conducted or what you can or cannot do or what  
13 you will or will not do. It is much more basic than  
14 that. From the point of view of the applicants, it  
15 is a question of their right, if any, to participate  
16 in the process at all; not the manner of that  
17 participation, but their right to be here. Clearly  
18 that is a threshold question. Nothing can be more  
19 final from that point of view than a determination  
20 by you that they don't have a substantial and direct  
21 interest and, therefore, can't take part. That is  
22 the first point that I would like to make.

23 The second point I would like to make  
24 is that it seems to me again, in weighing whether or  
25 not you should state a case, you must be mindful of  
whether there is any merit whatsoever in the arguments





11 1 that are being urged upon you as to the submissions  
2 that you have erred.  
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4 Now, I think we can both agree, and  
5 I can readily concede that if there is no merit what-  
6 soever, if it is just a bald proposition that there  
7 is no merit then that is the end of it and you  
8 shouldn't waste the Divisional Court's time in stating  
9 essentially a frivolous case.

10 I submit to you with great respect, sir,  
11 that that is clearly not the case here.  
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There is more than some merit, there is more than some prima facie merit. I think what has happened, if I can take the liberty of saying this, is that there is an honest and a genuine difference of opinion between the Counsel representing that group of people and yourself as to the meaning to be attributed to the word "substantial" and "direct". Although it has been less than 24 hours since we have had your judgment in our possession, we have not had a great deal of time to research the law. I think it is fair to say there is not a great deal of the law directly on point. It is not a phrase that has been judicially interpreted on a number of occasions, and it is not a clear question.

More importantly than that, the question seems to me to be not just that of a substantial interest, but the word that I have the most difficulty with, sir, and in understanding your decision is "direct". The test is substantial and direct. Now it is obvious here that this is the question of central and very critical importance to the people who have made the application. I think in deciding whether or not you should state a case you have to look at who the applicant is, and in this case, I would submit to you as I did in argument, that the







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application really in fact is made on behalf of what I referred to as the "victims". Now the victims granted were the babies, the babies are gone, they are not here and they cannot make submissions to you. The families of those babies are the ones who are left behind to deal with the tragedy of the loss, and not only the loss but all of the things that ensued after the loss, the conduct of the entire investigation. So that really the parents, in my submission, are the victims here.

It is because of the critical importance of this question that I think it can be rightfully said that this would be a proper case to state a case, and it is for this reason. What it comes down to in the end, and what we are really looking at, is the question of whether or not the victims themselves have any right to participate in a process which is essentially designed to find out if those who are charged with doing justice have discharged their obligation, an obligation which I point out they owe, in my view, not just to society in general but directly, very directly to the victims. That is really what we are here looking at in Phase II. Was that obligation discharged? Was everything done that should have been done? Was it done properly? Were the judgment calls that were made





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judgment calls that in the light of your analysis on the evidence that you will hear in Phase II judgment calls that you can vindicate?

THE COMMISSIONER: Isn't this exactly what the Commission Counsel are supposed to be doing? Is there anything else - I know you can contribute the benefit of an additional mind, or additional minds. Is there anything that you can contribute otherwise?

MR. TOBIAS: Well, sir, I don't think it is a question of what we can contribute, with respect, I think that is irrelevant.

THE COMMISSIONER: It is not totally irrelevant.

MR. TOBIAS: In answer to your question, I would say that all 15 or 20 Counsel here are here for that very purpose.

THE COMMISSIONER: Well I have already indicated with some Counsel that they are not to have full participation, although perhaps I did not say that, full participation in this matter, because their interests are only the interests of their clients.

MR. TOBIAS: But with respect, sir, that is a different matter.

THE COMMISSIONER: They have an interest in the propriety or otherwise of the conduct





FF 4

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of the Police and the conduct of the Crown Attorneys.

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MR. TOBIAS: But with respect, sir,  
the distinction that I am seeking to make, you are now  
characterizing the manner in which they discharge  
their obligations and how broad a view they take, how  
broad a role they play But quite apart from that  
this is not a trial, this is a Royal Commission, and  
in fact every Counsel in this room has the identical  
obligation. That obligation, sir, is to assist you  
with respect to the subject matter of the Inquiry.  
So when I frame a general question of looking into  
whether or not justice is done, yes, it is true, that  
is what Commission Counsel are here for and that is  
what every other Counsel is here for as well. The  
real question --

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THE COMMISSIONER: Not quite, they owe  
a first duty to their clients. Whereas Mr. Lamak and  
Miss Cronk, their first duty is to the Commission, so  
there is a difference.

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MR. TOBIAS: It is a very subtle  
difference, sir.

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THE COMMISSIONER: No, I don't find it  
subtle at all, I find it easy to understand.

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MR. TOBIAS: Were those two competing  
interests, sir, in conflict protecting the rights of







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their client and holding their client's position and assisting you, there is no doubt in my view whatsoever the way you have to go is to assist you.

THE COMMISSIONER: No. I am sorry, I think it is the other way around. Perhaps I am old fashioned, I think your first duty is always to your client. I have always accepted that as being the duty of Counsel. Unfortunately for Mr. Lamek and Miss Cronk their client is the Commissioner.

MR. TOBIAS: I will argue, sir, that is quite true in the adversarial process where there is trial. I think there is a basic distinction here. I think what we all have to be engaged in is a search for the truth, I think that is our first obligation.

THE COMMISSIONER: I hate to go on national television saying I don't think that is your first duty, I think your first duty is to your client. I think the first duty of Mr. Lamek and Miss Cronk is as it happens the truth, because that is what I am supposed to do is find out the truth. Your position, your first duty is to your client. Now you may have been brought up in a more altruistic and perhaps a more honourable way than I was, but that is my view of what your obligations are. Now, okay, we disagree on that. I think it is different. What you want to do





FF 6

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2 really is what you are trying to do, you are trying  
3 to change your position, you are trying to get a  
4 position as - you remember my saying perhaps a little  
5 rudely to Miss Kitley, was she trying to act as a  
6 junior counsel to Mr. Sopinka. I ask you, do you want  
7 to act as a junior counsel to Mr. Lamek? I don't think  
8 that is what you are supposed to be doing, you are  
9 supposed to be acting for your clients. Now in the  
10 first Phase I could understand that because you wanted  
11 to find out for your client what was the cause of  
12 death of Jordan Hines. You were in fact really, as I  
13 say, representing the late Jordan Hines in determining  
14 what the cause of his death was, therefore you did  
15 form as I saw it a special interest, a direct and  
16 substantial interest.

17 What you want to do now is you want to  
18 examine the conduct of the Police, and that is what  
19 Mr. Lamek and Miss Cronk are supposed to be doing.  
20 What Mr. Sopinka certainly will be doing when he  
21 examines, or cross-examines the witnesses, that will  
22 be his purpose. I don't think that is what you should  
23 be doing. I think you should still be acting, if at  
24 all, for the parents of Jordan Hines and I don't think  
25 that the parents of Jordan Hines have any special or  
substantial interest, any direct or substantial interest.





FF 7

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2 If we use interest in the legal sense of interest as  
3 opposed to the academic sense, which I can fully under-  
4 stand and which I tried to express in my reasons I  
5 don't blame you, I think that is quite right and they  
6 probably should be more interested, but everybody is  
7 more interested in things that are closer to them, but  
8 we can't have everybody with a direct and substantial  
9 interest. Susan Nelles has one because she was  
10 arrested. The Police have one because they are  
11 accused of arresting her without proper investigation.  
12 The Attorney General has one because he is accused of  
13 prosecuting her without proper consideration. Maybe  
14 I haven't expressed that well, but that is what has  
15 happened.

16 The others I have said that they may  
17 come in because something may be said about them and  
18 their may be some suggestion that they behaved  
19 improperly. It may be that 5-2 will come into play  
20 and they will be able to defend their clients' interest.  
21 That does not mean as far as I am concerned that the  
22 others are going to be allowed to investigate the  
23 Police and the Crown Attorneys.

24 If I am right in that, and this is going  
25 to make Phase II a much more efficient and speedy  
operation. That is not the reason I am doing it, but







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if I am right in it that is what is going to happen. It is not going to be assisted if we have - well perhaps I shouldn't say that. I am not suggesting that you wouldn't be of help but as I have said to you outside any lawyer in Toronto would be of assistance to me but it is just whether I can afford the luxury of having every lawyer in Toronto assisting me in this investigation. That is a long speech.

MR. TOBIAS: Well, no, but in fairness I will reply to it very quickly. There are three areas. The first one of course is that, I am sorry, I tried very hard, sir, and I say that sincerely, to understand this distinction between Phase II, Phase I and Phase II, and the conundrum I have is that Mr. Lamek and Miss Cronk were looking into the cause of death.

THE COMMISSIONER: That's right.

MR. TOBIAS: Of all 36, including Jordan Hines.

THE COMMISSIONER: That's right.

MR. TOBIAS: So they were charged with that obligation, and to that extent there was duplication in having his Counsel here at all in Phase I; that is point one.

THE COMMISSIONER: I understand that, there is a fine distinction.





FF 9

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2 MR. TOBIAS: Well, extremely fine, and  
3 because it is so fine, sir, and I think this is what  
4 I was trying to say to you earlier, because it is so  
5 fine it may very well be that others may see it  
6 differently, and that is the question you have to  
7 determine today. I am not here to argue the case on  
8 the merits, I have already done that and you have  
9 ruled against me and I accept that, but it is such a  
10 fine distinction, and I submit such a critical point  
11 that it becomes very very difficult for you to say,  
12 no, we won't have it reviewed, we won't look at it.

13 Now if I can just finish in response to  
14 what you have advised me. Commission Counsel always  
15 have somewhat of a duplicate role, certainly as I  
16 perceive their role, they act for you, and that means  
17 they act for the public in a global sense. Therefore,  
18 they really act for every one of those 36 sets of  
19 families and I concede that. However, what we are  
20 looking at here is whether those 36 sets of families  
21 have not only a substantial but a direct interest. It  
22 is very hard for me to accept your view, sir, that the  
23 role of, or the interest of John Doe standing at the  
24 corner of Dundas and University is direct, is as direct  
25 with respect to the investigation of Jordan Hines'  
death as June and Adrian Hines, I just can't accept





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FF 10 2 that, I apologize, but I can't.

3 Also in terms of your last comment I  
4 think we belaboured the point sufficiently. I just  
5 underline that one more time. Yes, the efficiency  
6 is a good thing, it is to be desired, it is to be  
7 coveted, it is not the only consideration nor can it  
8 be.

9 I guess what I am really saying,  
10 Mr. Commissioner, is what we are looking at here, in  
11 my view, is the right of the victim to play a role in  
12 the process, to participate. I certainly cannot think  
13 of any more central question than that. I think it  
14 really is that succinct a point when you boil it all  
15 down that is what it all comes to, and because it is  
16 quite that succinct and because to me it is quite that  
17 central, and because the ruling is based really on  
18 such a fine distinction, it is inconceivable to me  
19 at this point that you could consider refusing to state  
20 a case and entertain another view on the question.

21 THE COMMISSIONER: There is a practical  
22 difficulty about stating the case, you understand the  
23 practical difficulties?

24 MR. TOBIAS: I am fully aware of the  
25 practical difficulties.

THE COMMISSIONER: It means if I state







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a case you cannot proceed with Phase II because obviously Section 6, ss. 4, apply a stated case and then pending a decision of the Divisional Court we can proceed. We can't proceed without your having standing, and if I give you standing now notwithstanding everything I have said, then I might just as well not have made the ruling at all, it is unfortunate, but that is what happens.

MR. TOBIAS: My only response to that, sir, and I hope you don't misinterpret this, and I take a chance I suppose and I put it to you this way. I mean no disrespect whatsoever, no disrespect whatsoever, but in fairness, sir, I acknowledge that the practical problem is a serious one. Questions of very critical importance such as this cannot be decided on the basis of practical circumstances, they have to be decided on the basis of justice, practicalities aside.

THE COMMISSIONER: There is another justice we have to consider and that is there must be a report some day and the report and the efficiency is part of justice too.

MR. TOBIAS: Yes, I recognize that.

THE COMMISSIONER: You have to balance, I have been on a balancing act here ever since I started





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this and sometimes I seem to have balanced wrong. If we were to now leave this to go through this litigious process. If I were to state a case now, nothing that I decide, and I am not being abusive here satisfies everyone; if I were to decide now okay, this is a good issue let this go to the Divisional Court, the Divisional Court may say I am right and they may say I am wrong, I think it unlikely they will say I am wrong but I was wrong before and I can be wrong again.

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Now if that is the case if they decide against me we might decide to appeal; if they decide for me, you might decide to appeal. We would have to go to the Court of Appeal. Then somebody may then decide although I hope the time is now passed and no one has decided to go to the Supreme Court of Canada on this last one, but it might happen the next time, when do you see the end of this?

MR. TOBIAS: I cannot answer that, sir. However again I guess I'm taking the opposite side of the street now, we have to come back to what is practical and likely to happen. It is true it could conceivably be appealed from the Divisional Court to the Court of Appeal but if that were to happen we are certainly not talking about a fantastic delay.

THE COMMISSIONER: Yes, we are.

MR. TOBIAS: With respect, sir --

THE COMMISSIONER: There is a thing called a long vacation and the Court of Appeal does not sit on civil cases --

MR. TOBIAS: I recognize that but I think again we are having a genuine disagreement of opinion as I see it the outside time frame is about six weeks. There are eight weeks in July and







GG-2

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2 August. You probably will not get started until  
3 the second week of July, you will have to take one  
4 week off for some type of summer vacation. I guess  
5 what you are saying is that six weeks delay is just  
6 too long, the question is not that important, it  
7 is not that critical. What I am urging upon you  
8 is the opposite. I'm saying, yes, it is. I think  
9 a six week delay in the overall scope of things is  
10 a relatively short period. We are talking about the  
11 very right of these people to participate. After all,  
12 let us look at it. If these people did not exist,  
13 if they had not had these children, if they had  
14 not had the children in the Hospital none of us  
15 would be here. That is surely the central question.  
16 I cannot see how there could be a more direct  
17 interest than what. What has happened and what you  
18 are looking into happened to them. It did not happen  
19 to anyone walking the street, it happened to them.

18 THE COMMISSIONER: I understand that.

19 MR. TOBIAS: I guess where we are  
20 having a substantial difference of opinion I just  
21 don't see six weeks as being that critical if it  
22 means that you have to cut those people out.

23 THE COMMISSIONER: My understanding is  
24 not six weeks, I think six months. We started in  
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November and with the greatest cooperation - I think it was in November, the judgement on the naming of names, and we got from the Court of Appeal with the most tremendous cooperation the result, I think I have forgotten when, but I think it was April or May.

MR. TOBIAS: I believe we argued in the Court of Appeal in March and I believe the decision of the Divisional Court came down at the end of January. I can tell you for all of my friends because we have discussed this that we are prepared to argue in the Divisional Court this month, the last week of June. So hopefully when I say six weeks I would hope that if we lost and if someone wanted to appeal, I hope it could be dealt with at the beginning of the fall sittings by the Court of Appeal. But even that is not really important, whether it's six weeks or eight weeks, what difference does it make? I could see your concern if we were talking about holding up the process for a year. Yes, that would be something that would be unthinkable, but I do not think we are into that kind of situation.

About the possibility that, well, there is no guarantee that someone will not go off to





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the Supreme Court of Canada, that is true, there is no such guarantee, but we in determining whether or not the question is important enough to be ruled upon by a higher court, we have to look not at what is possible but what it likely to happen.

THE COMMISSIONER: Yes, all right.

MR. TOBIAS: Thank you, sir.

THE COMMISSIONER: Mr. Labow, have you anything further to say?

MR. LABOW: Mr. Commissioner, I adopt what Mr. Tobias has said but to be somewhat more direct, with the greatest of respect, I think that you have erred in your decision in narrowing your consideration of what interests are to the fact that in your opinion Phase II would not affect the legal interest of the parents in any way. It is my respectful submission that that is an error in the interpretation of what a direct and substantial interest is.

The case law is very vague in the area. I have canvassed some of the case law and it seems to indicate that anything that is of potential importance to an individual or would seriously affect an individual can be construed to be a direct and substantial interest. I would submit to you that







GG-5

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2 that includes more than financial effect or effect to  
3 their reputation, but any kind of effect. My clients  
4 feel very strongly that they have a place in Phase II,  
5 as I submitted to you previously in order to learn  
6 everything that went on.

7 Now, to try to distinguish their  
8 interest from the general public, aside from Mr. Tobias'  
9 comment that they feel they have a much greater interest  
10 than the gentleman who is walking down at the corner  
11 of Queen and Bay right now, you have indicated in  
12 your decision that the parents are the only  
13 representatives of the babies themselves and I agree  
14 with that wholeheartedly. The parents are the  
15 only representatives of the babies themselves and  
16 that is why they feel they have a place in any  
17 proceeding that deals with the babies in any way.

18 Now you have indicated that Mr. Sopinka  
19 has an interest because he will look at the conduct  
20 of the police, but he is looking at the conduct of  
21 the police towards his client, Miss Nelles. Everybody  
22 here as you told Mr. Tobias has as their main interest  
23 whatever they owe to their clients. The parents'  
24 interest is very clear; their interest is solely  
25 to find out anything and everything that happened.  
They do not want to not have a fact emerge that might





GG-6

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harm their client because they won't be harmed.

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They want to know whether it hurts them or not and

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hurts them in an emotional sense.

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THE COMMISSIONER: What is it that

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they want to know about the investigation? What

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is their greater interest, what is their direct and

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substantial interest in the conduct of the police?

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MR. LABOW: Their direct and substantial

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interest is to learn exactly for example what the

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police thought and did when they looked into the

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death of Justin Cook. Mr. and Mrs. Cook want to

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know exactly what the police did. They know what

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they told the police; they know any direct contact

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that they had with the investigators. They know

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a number of things that Commission Counsel cannot

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know unless they take the time to talk to each of

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the 36 sets of parents whose children were involved

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in the Commission, but I will reduce that to the

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20 odd sets of parents whose children were directly

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involved in the prosecution. I do not think

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Commission Counsel has the time to do that but there

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are 11 sets of parents who felt that they had enough

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of an interest that they wanted to be here in Phase I

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and they still want to be here in Phase II.





GG-7

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2 What we are interested in is the  
3 conduct of all the parties involved in Phase II  
4 towards those individual children and that is why  
5 I feel that you narrowed the scope of direct and  
6 substantial interest too greatly. You just narrowed  
7 it down to a specific focus. What kind of effect  
8 will it have on them?

9 I submit to you that that is not  
10 the proper test. I also should point out that, with  
11 the greatest of respect, if the parents don't have  
12 an interest then they don't see why virtually anybody  
else in Phase II has much of an interest.

13 THE COMMISSIONER: The police and the  
14 Crown Attorney and Susan Nelles have an interest.

15 MR. LABOW: That is it.

16 THE COMMISSIONER: That is really all  
17 I said. They are the only people that I recognize  
to have an interest.

18 MR. LABOW: But you granted standing  
19 to the Hospital and the parents cannot understand  
20 the Hospital's greater direct interest and substantial  
21 interest than theirs.

22 THE COMMISSIONER: Can I help you in  
23 that. There is another section and that is 5-(2)  
24 and that is what concerns me. The Hospital, the  
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doctors and the nurses, their names are going to be bandied about and their names are going to be bandied about in a manner that may reflect upon them and for that reason I have allowed those other people to be here for that limited purpose. That is all that most of them are asking for. The nurses were asking for something more but I have limited it so they don't get it - at least that is my aim. But there's no limitation as far as you are concerned, there cannot be any limitation because you have to go over the whole of the investigation if you are going to be of any use to your clients at all.

MR. LABOW: I agree 100%.

THE COMMISSIONER: And that is exactly what Commission Counsel is going to do.

MR. LABOW: I think Commission Counsel have to look at it from a different point of view. They have to take the broader focus. They have to look at the general investigation, the general actions of the coroner's, the general actions of the Crown Attorney. The parents are saying that is not what we want, we want someone to focus on these actions as they regard our children. Surely that is as direct and substantial an interest as anyone could have and, with the greatest of respect,





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it is our submission that you have ignored that aspect of what interest can be and that it why we would also like you to state a case in this matter. Thank you.

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THE COMMISSIONER: Thank you.

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Mr. Shanahan?

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MR. SHANAHAN: Well, Mr. Commissioner, I adopt what has gone before me, what Mr. Tobias and Mr. Labow have said. I ask you, sir, that you would state a case for the following reasons as it pertains to those two families that I represent here.

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I put to you, sir, that willy-nilly Mrs. Dawson has become involved in Phase II. She is involved in the investigation, sir. Unwittingly, if you like, she has been banging on the door since July of 1980. She has gone to those officials in charge and she has put to them her suspicions. To say to this lady now and to that family that you can leave now, you can exit that --

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THE COMMISSIONER: She is involved as a witness, she is not involved as a party. The evidence that she has given is evidence that will be relevant to Phase II, I accept that. How does that make her any more involved as a party merely





GG-10

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2 because she had suggested to the coroner that  
3 he should investigate the state of the child's  
4 digoxin?

5 MR. SHANAHAN: I think, sir, insofar  
6 as you would assess whether she has a substantial  
7 and direct interest, to bring it specifically to  
8 her case rather than to broader cases, I put to  
9 you, sir, that her having conveyed that, what  
10 he did with it, or what he did not do with it, whom  
11 he passed it on to, when he passed it on, what was  
12 done about that, quite apart from the ramifications  
13 it may have for all subsequent deaths, the Hospital  
14 practices or whatever, I put to you, sir, that to  
15 tell her at this stage, she exits, she has no further  
16 concern , she does not speak through or attend  
17 through her Counsel here, I put it to you, sir, that  
18 I respectfully disagree with that. We feel that she  
19 has been involved genuinely and seriously in it  
20 through her suspicions and through those people that  
21 she contacted and that she is vitally interested in  
22 Stage II.

23 I put to you as well as I think  
24 Mr. Tobias put to you, and I would simply state that  
25 this Commission, sir, Phase I and Phase II is the  
upshot of those babies deaths. It is really trite







GG-11

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2 but the fact remains that those deaths and the  
3 people that cared for those children, took them  
4 to those institutions to care for them really are  
5 the central core and everything that flows from that  
6 has flowed from those deaths. Someone like the  
7 Lombardos and the Dawsons, Mrs. Dawson for her  
8 part referring to the suspicions that she had; the  
9 Lombardos, their child being exhumed, a pivotal  
10 child in the investigation, those people are vitally  
11 interested. If you knock out this house of cards,  
12 the bottom set of cards that is the parents. the  
13 death of the children and their families is a factor  
14 in the investigation and the Commission is going to  
15 discount that.

16 Finally, sir, the effect of your  
17 ruling is that, I would submit, the fact that we  
18 are the only parties who are effectively excluded. The RNAC  
19 included and it is my feeling, with all due respect,  
20 there is not a great deal of merit to 39,000 people  
21 being represented, but in any event, sir, I do  
22 think your ruling has not effectively shunted them  
23 out here as 39 nurses are here represented by the  
24 same Counsel who would have represented the RNAO.

25 I see, sir, and my clients certainly  
see it very clearly that the net effect of your





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ruling is that those people who were the cause  
of this Commission at the upshot have effectively  
been eliminated.

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Limited status, sir, I gathered you  
would give limited status to certain people that  
they would be here but their right to question  
people or examine people would be limited. We have  
not been granted that. We have been completely  
shut out and as I say the effect of the ruling of  
this Commission now is that the only parties really  
who are not entitled to carry on are the parents  
of the children. I would respectfully suggest, sir,  
that whether you are right or wrong there are merits  
to other parties coming in.

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THE COMMISSIONER: Mr. Shinehoft.

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MR. SHINEHOFT: Mr. Commissioner,  
other than the question of obligation to the client  
as opposed to obligation to the Commission that my  
friend, Mr. Tobias, has discussed with you, I adopt  
the submissions made by my other counsel, my other  
friends.

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I would point out, Mr. Commissioner,  
that I think it is your concern and it is your desire  
to have a report as quickly as possible, but also I  
think it is your concern to have a report that is  
accepted and that is by all the parties who have  
participated in these proceedings, and I am suggesting  
to you that if you leave out the parents' counsel,  
as far as Phase II is concerned, you are going to  
have a report published in due course that perhaps  
will not be as accepting by the parents, themselves,  
as well as the public, than if you had an opportunity  
to allow the parents' counsel to be present.

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I am suggesting, Mr. Commissioner, that  
you are concerned about getting the report out. You  
said to my friends that it is a balancing act and an  
act that you have been required to follow, an act  
that you have been required to follow from almost the  
beginning of these proceedings and there are a couple







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2 of ways of allowing us to be involved.

3 Firstly, you could state a case.

4 In terms of getting us to the Divisional Court, I  
5 am sure with the influence you have, Mr. Commissioner,  
6 you could get there in short order, that we are  
7 prepared to argue this case in front of the Divisional  
8 Court at the end of the month which is a couple of  
9 weeks. So surely that will not be a problem, however  
10 you have indicated to us, well what about the Court  
11 of Appeal? What about if the decision comes out in  
12 one of the interveners, if there are any, who wishes  
13 to appeal any decision made by the Court of Appeal  
14 or made by the Divisional Court?

15 I am suggesting that the likelihood  
16 of interveners being involved is rather minimal and  
17 suggesting that if we are successful, for example,  
18 in the Divisional Court, and that is being presumptuous,  
19 but if we are the likelihood of an appeal is rather  
20 minimal.

21 The next question is what happens if  
22 we are not successful? You are involved in a situation  
23 where you want to get on with Phase II. You have a  
24 pending appeal and, as Mr. Tobias has said, hopefully  
25 it will not take that length of time, but one other  
alternative is to grant us limited standing during that





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2 period of time and proceed with Phase II, so that if  
3 we are successful in the appeal nothing has been  
4 lost and if we are unsuccessful then maybe we have  
5 been granted standing for no longer than I would  
6 suggest a month and then at that time our standing  
7 can be terminated and you can proceed with Phase II,  
8 as expeditiously as you can and that would be the end  
9 of the matter as far as any further appeal. I think  
10 the likelihood of that is rather miniscule. I don't  
11 think it is an important consideration.

12 So in the main my submission is that  
13 I think you have to be concerned about how the public  
14 in general and the parents, in particular, are going  
15 to view your report. I think that you want general  
16 acceptance of your report. I think it will be perhaps  
17 a reaction against your report if we are not permitted  
18 some sort of representation as far as Phase II, and  
19 it is for those purposes that I ask you, Mr. Commissioner,  
20 to state a case.

21 THE COMMISSIONER: Thank you, Mr.  
22 Shinehoft. Is there anyone supporting the position of  
23 the parents in this matter?

24 Well I am going to dismiss the  
25 application for a stated case and I am going to give  
oral reasons now without calling on anyone else, I





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2 reserve the right to adjust these reasons later if  
3 the matter goes further. Mainly the adjustment  
4 though are to matters of syntax and not of substance.

5 For the reasons I have given, and  
6 notwithstanding the able argument of counsel for  
7 the parents, I am not persuaded that there is an  
8 arguable case that they have a substantial and  
9 direct interest in that part of the Commission which  
10 we have designated as Phase II.

11 Every interest that is involved in  
12 the Order-in-Council and the particular part of it  
13 concerning the Phase II is fully represented, not only  
14 by Commission Counsel, but by those who, in my view,  
15 do have a direct and substantial interest, namely  
16 Susan Nelles, the Police and the Attorney-General,  
17 therefore the Commission cannot in a legal sense suffer  
18 from the exclusion of the parents.

19 To me it is of vital importance for  
20 the efficiency of the Commission that I do not state  
21 a case when I have and I will concede, of course,  
22 that I may be wrong, but I do not entertain any  
23 doubts on the matter.

24 If a case is stated Section 6,  
25 Subsection 4:

"Requires that no further proceedings







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3 "should be taken by the Commission  
4 with respect to the subject matter of  
5 the stated case, but it may continue  
6 its inquiry into matters not in issue  
7 in the stated case."

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9 As I read that I would be unable to  
10 proceed with Phase II if I were to state a case.

11 Now I ask the parents to understand  
12 that, as I said before, this decision is made  
13 reluctantly. I fully understand the tremendous  
14 concern and interest in the academic sense that the  
15 parents have, not just in the cause of death, but in  
16 all of the proceedings that took place after, and if  
17 I should prove wrong in this decision, which I do not  
18 expect will happen, but which does happen and has  
19 happened in the recent memory of all of us, if I  
20 should prove wrong I will gladly, happily adjust the  
21 proceedings accordingly.

22 Now it is not unusual for a court  
23 of a body to indicate the remedy available to the  
24 dissatisfied litigant, but under Section 6 of the  
25 Public Inquiries Act, Subsection 2:

"If the Commission refuses to state  
a case under Subsection 1..."

Which is what I have been asked to do:





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"...the first person requesting it  
may apply to the Divisional Court for  
an Order directing the Commission to  
state such a case."

That procedure is open to you and over the noon hour  
I spoke to the Division Court - not to the Court  
itself, but to the officers of the Court and there  
is an available date on the 28th of June, which is  
a Thursday, by which time as I anticipate that the  
argument in Phase I will be finished, and I also  
anticipate that the proceedings in Phase II will not  
have commenced.

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I am not suggesting or encouraging that the parents will take that action, but that is available to them and, as I say, if I prove to be wrong I will happily adjust the proceedings accordingly, but there are two reasons why I will not state a case. There are more than two reasons.

The first one is that I am not persuaded that I was wrong and the reasons I gave yesterday and if I state a case, because of the appellate procedures that are available to every one, I am convinced that it will delay almost intolerably these proceedings and that is one thing that I think is very important in all Commissions and perhaps it will become particularly important in this one that we try to avoid.

So there we are. Does anyone have any comment?

MS. KITELY: Not on the stated case, sir. I have another small comment.

THE COMMISSIONER: Yes, all right.

MS. KITELY: For logistical reasons Miss Symes and Miss McIntyre and I may have some difficulty being here tomorrow. We don't want to have you pull the troupes and miss us out in our times. If you are asking tomorrow afternoon for how long people will







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be we don't expect to be longer than an afternoon.

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THE COMMISSIONER: Longer than an  
afternoon?

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MS. KITELY: Yes.

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THE COMMISSIONER: In the ordinary  
course you won't come on, I suppose, the earliest will  
be Monday.

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MS. KITELY: I appreciate that, sir,  
but I thought you might be canvassing tomorrow.

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THE COMMISSIONER: I hope to be  
finished next week, but I would be surprised. I  
hope that if anybody accepts the invitation I just  
offered that we will be finished, at least by the  
28th of June.

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Any other comments?

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MR. YOUNG: On a related matter,  
Mr. Percival has a problem on Thursday of next week  
and we would very much appreciate being given the  
privilege to argue on Monday, Tuesday or Wednesday.  
There is some leeway there and I think it may well  
work out. I did want to put that on the record.

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THE COMMISSIONER: He has trouble you  
say?

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MR. YOUNG: On the Thursday of next  
week.

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2 THE COMMISSIONER: I would anticipate  
3 that we would be at least starting with either Miss  
4 Kitley or the parents by Thursday.

5 Have you any thoughts on how long  
6 you will be, Mr. Hunt?

7 MR. HUNT: I can't see us being any  
8 longer than an afternoon.

9 THE COMMISSIONER: Well, Mr. Sopinka  
10 told me he was going to be short. Do you know how  
11 long Mr. Strathy will be?

12 MS. RAE: I believe half a day to a  
13 day. Probably half a day.

14 THE COMMISSIONER: We will be in to  
15 you if I can express it as inaccurately as that, on  
16 Monday afternoon I think and you will be finished by  
17 noon on Tuesday. I think that is when you can expect  
18 to go on.

19 MR. YOUNG: Yes, sir. And for other  
20 counsel's assistance I would think we would be no  
21 more than half a day, likely closer to an hour and  
22 a half or two hours.

23 THE COMMISSIONER: Miss Kitley, it  
24 looks like Wednesday morning. It means that we will  
25 start with the parents and the parents will have to  
complete the matter by, -- in order to allow everybody





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we have to come back up the line again, so I am  
hoping that the parents will have finished the matter  
at least by Monday of the following week.

Anyway, we will have to see what  
happens. It may be that we will still be going in  
July on this, but that is what I certainly want to  
avoid.

Anything else? All right. Then until  
10 o'clock tomorrow morning.

---Whereupon the hearing adjourned at 4:55 p.m. until  
10:00 a.m. Thursday, June 14, 1984.

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